Public Employees' Benefit Board (PEBB)
Providence Choice Plan
Member Handbook

Effective January 1, 2008

Administered by:

Providence Health Plan
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1. INTRODUCTION

TO: State Employees and Non-Medicare Eligible Retirees

FROM: Public Employees' Benefit Board (PEBB)

The benefits described on the following pages were designed to provide you and your dependents with the best possible medical care at competitive rates. PEBB has designed this Plan in cooperation with Providence Health Plan. The benefits under the Plan are provided by PEBB on a self-insured basis. Because this Plan is self-insured, it is subject to PEBB's funding limitations, including but not limited to legislative appropriations, PEBB fund balances, and the limits imposed by laws that apply to PEBB. PEBB has contracted with Providence Health Plan to process claims and provide customer service to Participants. However, Providence Health Plan does not insure or otherwise guarantee any benefits under the Plan.

Should you require additional information concerning this medical plan or any other topic related to your medical insurance, please contact the insurance company at the numbers listed below, or PEBB at (503) 373-1102, 1-800-788-0520 (outside Salem), or via e-mail at inquiries.pebb@state.or.us.

If more than one year has lapsed since the effective date of your member handbook, benefits may have changed. In all cases, benefits will be administered in accordance with the governing plan documents, insurance contracts or applicable Federal and State regulations.

Customer Service Quick Reference Guide:

Medical and prescription drug claims and benefits	503-574-7500 (local / Portland area) 1-800-878-4445 (toll-free) 503-574-8702 (TTY local) 1-888-244-6642 (TTY toll-free) www.providence.org/healthplans
Mail order prescription drug services www.providence.org/healthplans/members/pharmacy	
Medical Prior Authorization Requests	1-800-638-0449 (toll-free)
Mental Health / Chemical Dependency Prior Authorization	1-800-711-4577 (toll-free)
Providence RN medical advice line	503-574-6520 (local / Portland area) 1-800-700-0481 (toll-free)
Providence Resource Line for health education classes	503-574-6595 (local / Portland area) 1-800-562-8964 (toll-free)

2. BENEFIT SUMMARIES

FULL TIME EMPLOYEES

IN-PLAN benefits apply to *Medically Necessary Services* provided by a *Medical Home Provider* or from a specialist in the *Providence Choice Network* when care is coordinated by the *Medical Home Provider*. OUT-OF-PLAN benefits apply to *Medically Necessary Services* provided by a *Non-Participating Provider* or when *Services* have not been coordinated by a *Medical Home Provider*. Many *Services* must be *Prior Authorized* (see section 3.6 for *Prior Authorization* requirements).

The annual (calendar year) *Out-of-Pocket Maximum* for IN-PLAN *Covered Services* is $1000 per person / $3000 per family and for OUT-OF-PLAN *Covered Services* it is $ 2000 per person / $ 6000 per family. *Your Copayments* or *Coinsurance* for the following *Services* do **not** count toward the *Out-of-Pocket Maximum*: Prescription drugs, hearing exams, hearing aids, infertility and alternative care. (See the definition of *Out-of-Pocket Maximum* for additional details.) **The *Lifetime Maximum Benefit* is $2,000,000.**

Benefits	**You Pay: IN-PLAN**	**You Pay: OUT-OF-PLAN**
Preventive Health *Services*		
• Periodic health exams, well-baby and well child care (to age 19)	$0	30%
• Routine immunizations/shots	$0	0%
• Physical exam to obtain commercial driver's license (for employees only; see section 5.2.1 for voucher requirements)	$0	30%
• Hearing screenings	$0	30%
Women's Health Care *Services* (direct access, no referral required)		
• Annual calendar year gynecological exams, Pap tests	$0	30%
• Follow-up visits after annual gynecological exam	$5/visit	30%
• Mammograms	$0	30%
Physician / Provider *Services*		
• Office visits to a *Medical Home Provider*	$5/visit	Not Applicable
• Office visits to other providers	$5/visit	30%
• E-visits to a *Participating Provider*	$5/visit	Not Covered
• E-visits to a *Medical Home Provider* for treatment of diabetes	$0/visit	Not Covered
• Inpatient hospital visits, including surgery and anesthesia	$0	30%
• Surgery and anesthesia performed in a provider's office	$5/visit	30%
• Allergy shots, serums and injectable medications	$5/visit	30%
• Family planning and related *Services*	$5/visit	30%
• Alternative care visits from any *Qualified Practitioner* (limited to $1000 per calendar year)	$10/visit	$10/visit
• Other office procedures	$5/visit	30%
***Hospital* and Inpatient Services,** including • Acute care • Rehabilitative care (30 days per calendar year; 60 days for • head and spinal cord injuries) • *Skilled Nursing Facility* (180 days per admission)	$50/day, maximum of $250/admission	30%
• Bariatric surgery (In-Plan coverage only)		Not Covered
Maternity *Services*		
• Pre-natal visits, delivery and post-natal visits	$0/visit	30%
• *Hospital Services* related to delivery	$50/day, maximum of $250/admission	30%
• Hospital service related to routine newborn nursery care	$50/day, maximum of $250/admission	30%
• Infertility services	50%	50%

Medical Supplies, including *Durable Medical Equipment*, appliances and prosthetic devices	15%	30%
Diabetes Supplies	$0	$0

Emergent/Urgent & Ambulance *Services* (the *Copayment* shown is waived if admitted to *Hospital* within 24 hours)		
• Emergency services (for *Emergency Medical Conditions* only)	$75	$75
• Urgent care services (for non-life threatening illness/minor injury)	$25/visit	30%
• Ambulance *Services* (for emergency transportation only)	$75	$75
Other *Covered Services*		
• X-ray and lab *Services*	$0	30%
• Outpatient rehabilitative *Services* (60 visits per calendar year)	$5/visit	30%
• Outpatient surgery, dialysis, chemotherapy, radiation therapy and cardiac rehabilitation	$5/visit	30%
• Temporomandibular joint (TMJ) *Services*	Same as other medical Services	Not Covered
• Home health care and home infusion *Services* (limited to 180 visits per calendar year)	$5/visit	30%
• Hospice care	Covered in full	Covered in full
• Hearing exams	$5/visit	30%
• Hearing aids (limited to $4000 per person every 4 calendar years)	10%	10%
Mental Health / Chemical Dependency *Services*		
• Outpatient *Services*	$5/visit	30%
• Inpatient *Hospital Services* and Residential/Day *Services*	$50/day, maximum of $250/admission	30%

PRESCRIPTION DRUG SUMMARY OF BENEFITS
(See additional details in section 15)

Retail: For prescriptions filled at a participating retail pharmacy, **for up to a 30-day supply**:

- **Generic drugs:** $5 *Copayment*
- **Preferred (formulary) brand name drugs:** $15 *Copayment*
- **Non-preferred (non-formulary) brand name drugs:** $50 *Copayment* or 50% *Coinsurance*, whichever is greater, **when a generic equivalent is not available** (see note below)

Mail Order: For prescriptions filled via the mail order provisions of this Plan, **for up to a 90-day supply**:

- **Generic drugs:** $5 *Copayment*
- **Preferred (formulary) brand name drugs:** $37.50 *Copayment* **when a generic equivalent is not available**
- **Non-preferred (non-formulary) brand name drugs:** $125 *Copayment* or 50% *Coinsurance*, whichever is greater, **when a generic equivalent is not available** (see note below)

Important Notes:

- An exception process is available if the prescribing provider believes that it is medically necessary for *You* to use a non-preferred (non-formulary) brand name drug instead of a preferred (formulary) brand name or generic drug. A request for medical exception that explains why the drug substitution is medically appropriate may be submitted by your provider to PHP. If the request is approved, the benefits for **preferred** (formulary) brand name drugs will apply. If the request is denied, the appeal rights described in section 9 will apply.
- If *You* request, or *Your* physician prescribes, a non-preferred (non-formulary) brand name drug when a generic equivalent is available, *You* will be responsible for the difference in cost between the non-preferred brand name drug and the generic drug, in addition to the non-preferred brand *Copayment*.
- *Copayments* and any difference in cost payments for covered prescription drugs do **not** apply to *Your* annual medical *Out-of-Pocket Maximum*.

PART TIME EMPLOYEES & RETIREES

IN-PLAN benefits are provided for medically necessary services when provided by a participating Medical Home provider or a participating specialist upon referral from a Medical Home provider. **OUT-OF-PLAN** benefits are provided when services are received from participating providers without referral authorization or non-participating providers. Benefits for non-participating providers are provided at usual, customary and reasonable (UCR) charges. Many services must be prior authorized or services will be denied.

The annual (calendar year) in-plan out-of-pocket maximum payable by you for any covered services is $2,000 per person/$6,000 per family; out-of-plan is $4,000 per person/$12,000 per family. *Your Copayments* or *Coinsurance* for the following *Services* do **not** count toward the *Out-of-Pocket Maximum*: Prescription drugs, hearing exams, hearing aids, infertility and alternative care. (See the definition of *Out-of-Pocket Maximum* for additional details.) **The lifetime maximum coverage for benefits is $2,000,000.**

BENEFITS	**You Pay:**	
	IN-PLAN	**OUT-OF-PLAN**
Preventive Health *Services*		
• Periodic health exams, well-baby and well child care (to age 19 and including lab & x-ray)	$0	50%
• Routine immunizations/shots	$0	50%
• Physical exam to obtain commercial driver's license		
• (for employees only; see section 5.2.1 for voucher requirements)	$0	50%
• Hearing screenings	$0	50%
Women's Health Care *Services* (direct access, no referral required)		
• Annual calendar year gynecological exams, Pap tests	$0/visit	50%
• Follow-up visits after annual gynecological exam	$30/visit	50%
• Mammograms	$0	50%
Physician / Provider *Services*		
• Office visits to a *Medical Home Provider*	$30/visit	Not Applicable
• Office visits to other providers	$30/visit	50%
• E-visits to a participating provider	$30/visit	Not Covered
• E-visits to a *Medical Home Provider* for treatment of diabetes	$0/visit	Not Covered
• Inpatient hospital visits, including surgery and anesthesia	$30/visit	50%
• Surgery and anesthesia performed in a provider's office	$30/visit	50%
• Allergy shots, serums and injectable medications	$5/visit	50%
• Family planning and related *Services*	$30/visit	50%
• Alternative care visits from any *Qualified Practitioner*	50%	50%
• Other office procedures	$30/visit	50%
***Hospital* and Inpatient Services,** including		
• Acute care		50%
• Rehabilitative care (30 days per calendar year; 60 days for head and spinal cord injuries)	$500/admission	50%
• *Skilled Nursing Facility* (180 days per admission)		50%
• Bariatric surgery (In-Plan coverage only)		Not Covered
Maternity *Services*		
• Pre-natal visits, delivery and post-natal visits	$0	50%
• *Hospital Services* relating to delivery	$500/admission	50%
• *Hospital service relating to* routine newborn nursery care	$500/admission	50%
• Infertility services	50%	50%
Medical Supplies, including *Durable Medical Equipment*, appliances, and prosthetic devices	50%	50%

Diabetes Supplies	$0	$0

Emergent/Urgent & Ambulance *Services* (the *Copayment* shown is waived if admitted to *Hospital* within 24 hours)		
• Emergency services (for *Emergency Medical Conditions* only)	$100	$100
• Urgent care services (for non-life threatening illness/minor injury)	$30/visit	50%
• Ambulance *Services* (for emergency transportation only)	$75	$75
Other *Covered Services*		
• X-ray and lab *Services*	20%	50%
• Outpatient rehabilitative *Services* (60 visits per calendar year)	$30/visit	50%
• Outpatient surgery, dialysis, chemotherapy, radiation therapy and cardiac rehabilitation	$30/visit	50%
• Temporomandibular joint (TMJ) *Services*	$30/visit	Not Covered
• Home health care and home infusion *Service* (limited to 180 visits per calendar year)	$30/visit	50%
• Hospice care	Covered in full	Covered in full
• Hearing exams	$30/visit	50%
• Hearing aids (limited to $4000 per person every 4 calendar years)	10%	10%
Mental Health / Chemical Dependency *Services*		
• Outpatient *Services*	$30/visit	50%
• Inpatient *Hospital Services* and Residential/Day *Services*	$500/admission	50%

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PRESCRIPTION DRUG SUMMARY OF BENEFITS
(See additional details in section 15)

Retail: For prescriptions filled at a participating retail pharmacy, **for up to a 30-day supply**:

- **Generic drugs:** $10 *Copayment*
- **Preferred (formulary) brand name drugs:** $25 *Copayment*
- **Non-preferred (non-formulary) brand name drugs:** $50 *Copayment* or 50% *Coinsurance*, whichever is greater, **when a generic equivalent is not available** (see note below)

Mail Order: For prescriptions filled via the mail order provisions of this Plan, **for up to a 90-day supply**:

- **Generic drugs:** $25 *Copayment*
- **Preferred (formulary) brand name drugs:** $62.50 *Copayment* **when a generic equivalent is not available**
- **Non-preferred (non-formulary) brand name drugs:** $125 *Copayment* **when a generic equivalent is not available** (see note below)

Important Notes:

- An exception process is available if the prescribing provider believes that it is medically necessary for *You* to use a non-preferred (non-formulary) brand name drug instead of a preferred (formulary) brand name or generic drug. A request for medical exception that explains why the drug substitution is medically appropriate may be submitted by your provider to PHP. If the request is approved, the benefits for **preferred** (formulary) brand name drugs will apply. If the request is denied, the appeal rights described in section 9 will apply.
- If *You* request, or *Your* physician prescribes, a non-preferred (non-formulary) brand name drug when a generic equivalent is available, *You* will be responsible for the difference in cost between the non-preferred brand name drug and the generic drug, in addition to the non-preferred brand *Copayment*.
- *Copayments* and any difference in cost payments for covered prescription drugs do **not** apply to *Your* annual medical *Out-of-Pocket Maximum or to any applicable medical plan deductibles.*

3. HOW TO USE YOUR PLAN

Coverage under this *Plan* is provided through:

- The *Providence Choice Network* of *Participating Providers* located in Clackamas, Multnomah, Washington and Yamhill counties (the *Service Area* for this *Plan*);
- A national network of *Participating Providers*, which allows *Participants* to take advantage of contracted fees when accessing care outside the *Service Area*; **plus**
- *Non-Participating Providers*.

With the design of this *Plan*, *you* will have lower out-of-pocket expenses when you obtain *Covered Services* from a *Medical Home Provider*, or are referred by your *Medical Home Provider* to a *Providence Choice Network* provider. *You* may, however, obtain *Covered Services* from a *Non-Participating Provider*, but that option will result in higher out-of-pocket expenses for most *Covered Services*. Please see the *Summary of Benefits* and section 3.2 for additional information.

The following *Covered Services* are available only under *Your* In-Plan benefits:

- All Human Organ/Tissue Transplants (see section 6.1);
- All Temporomandibular Joint (TMJ) *Services* (see section 6.3.1);
- All *E-visit Services* (see section 5.1.2);
- Bariatric Surgery and related services (see section 5.7.13); and
- Diabetic education programs (see section 5.9.4).

You are encouraged to choose a *Medical Home Provider* who will provide preventive and primary care *Services* and coordinate other care in a convenient and cost-effective manner (see section 3.1). **In order to receive In-Plan benefits for specialty *Services*, *You* must obtain referral authorization from *Your Medical Home Provider* before *You* receive the specialty *Services***.

Certain *Covered Services* require *Prior Authorization*, as specified in section 3.6.

Coverage under this *Plan* is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.

3.1 THE ROLE OF A MEDICAL HOME PROVIDER

The focus of this *Plan* is on maintaining *Your* health by encouraging wellness and preventive care. A *Medical Home Provider* can provide most of *Your* routine and preventive care and can refer *You* for appropriate specialty care (no referral is needed for women's health care *Services*). Because a *Medical Home Provider* knows *Your* health care history and has *Your* medical records, he or she can coordinate *Your* health care in a convenient and cost-effective manner. A list of *Medical Home Providers* can be found in the *Providence Choice Network* Participating Provider Directory.

Please see the Medical *Summary of Benefits* for coverage of Preventive *Services* from a *Medical Home Provider* and for women's health care *Services.*

So remember, it's to *Your* advantage to meet *Your* health care needs by using a *Medical Home Provider* or other *Providence Choice Network* provider or *Participating Provider* whenever possible.

3.2 SERVICES PROVIDED BY NON-PARTICIPATING PROVIDERS

Benefits for *Covered Services* by a *Non-Participating Provider* are provided as shown in the *Summary of Benefits*. See section 3.6 for *Prior Authorization* requirements.

Native American *Members* may also access *Covered Services* from Indian Health Services (IHS) facilities at no greater cost than if the Services were accessed from a *Participating Provider*. For a list of IHS facilities, please either visit the iHS website at http://www.ihs.gov, or contact the regional IHS office at:

Portland Area Indian Health Service
1220 SW Third Ave., #476
Portland, OR 97207
Telephone: 503 326 4123
Fax: 503 326 7280

3.3 SAMPLE BENEFIT CALCULATION FOR NON-PARTICIPATING PROVIDERS

If *You* choose to receive *Services* from *Non-Participating Providers You* will be responsible for costs that are not covered or allowed by this *Plan*, as shown in the following example.

Provider's standard charges	$100
Allowable charges under this *Plan* (accepted by *Participating Providers*)	$80
Plan benefits (for this example only)	$56 (70% benefit)
Balance *You* owe	$24
Additional amount that the *Non-Participating Provider* may bill to *You*	$20 ($100 minus $80)
Total amount *You* would pay	$44 ($24 plus $20)

3.4 EMERGENCY CARE SERVICES

An *Emergency Medical Condition* is a condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy. Some examples are:

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- Unexpected premature birth
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- *Medically Necessary* detoxification

If an emergency situation should occur, *You* should take immediate action and seek prompt medical care. *You* should call 911, or the emergency number listed in the local telephone directory or go to the nearest hospital emergency department.

Emergency room *Services* are covered when *Your* medical condition meets the guidelines for emergency care as stated above. *Covered Services* do not include *Services* for the inappropriate (non-emergency) use of an emergency room. This means *Services* which could be delayed until *You* can be seen in *Your Medical Home Provider's* office, for example: treatment of minor illnesses such as flu or sore throat, check-ups, follow-up visits and prescription drug requests.

3.5 URGENT/IMMEDIATE CARE SERVICES

Benefits include *Services* from an *Urgent/Immediate Care* facility or other provider and are covered as shown in the Medical *Summary of Benefits*. *Urgent/Immediate Care* does not include the care of an *Emergency Medical Condition*.

Urgent/Immediate Care Services are covered for non-life threatening conditions that require immediate attention such as ear, nose and throat infections, and minor sprains and lacerations. Out-of-Plan benefits apply to continuing or follow-up care at the *Urgent/Immediate Care* facility.

Urgent/Immediate Care Covered Services are provided when *Your* medical condition meets the guidelines for *Urgent/Immediate Care* that have been established by *Providence Health Plan. Covered Services* do not include *Services* for the inappropriate use of an *Urgent/Immediate Care* facility, including *Services* that do not require immediate attention such as: routine check-ups, follow-up visits, and prescription drug requests.

3.6 COVERED SERVICES THAT REQUIRE PRIOR AUTHORIZATION

While *Prior Authorization* is a requirement for coverage of certain *Services* under this *Plan*, *Prior Authorization* is not a treatment directive. The actual course of medical treatment that a *Participant* chooses remains strictly a matter between the *Participant* and his/her physician and is separate from the *Prior Authorization* requirements of this *Plan*. Further, *Prior Authorization* is not a guarantee of benefit payment under this *Plan* and a *Prior Authorization* determination does not supersede other specific provisions of this *Plan* regarding eligibility.

IN-PLAN SERVICES: *Participating Providers* are responsible for contacting *PHP* to obtain *Prior Authorization*.

OUT-OF-PLAN SERVICES: *You* or the *Non-Participating Provider* must contact *PHP* to obtain *Prior Authorization* for certain *Covered Services*. The current list of *Covered Services* that require *Prior Authorization* is available from the *PHP* customer service staff, as listed in Section 1.

PHP will provide a *Prior Authorization* form upon oral or written request. If *You* need information on how to obtain *Prior Authorization*, please call *Your* Customer Service Team at the number listed on *Your* Membership ID Card.

If an *Emergency Medical Condition* exists which prevents *You* from obtaining *Prior Authorization*, *PHP* must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, to continue coverage of these *Services*.

3.6.1 Prior Authorization Requests for Out-of-Network Services:

You or the *Non-Participating Provider* should call *PHP* at 1-800-638-0449 to obtain *Prior Authorization*. When requesting *Prior Authorization You* will need to furnish the following information:

- *Your* name.
- *Your* health plan identification number and group number (these are listed on *Your Providence Health Plan Member* identification card).
- *Your* date of birth.
- *Provider*'s name, address and telephone number.
- The name of the *Hospital* or treatment facility.
- Scheduled date of admission or date *Services* are to begin.
- Treatment or procedure to be performed.

3.6.2 Failure to Obtain Prior Authorization

If *You* do not obtain *Prior Authorization* as specified in section 3.6 above, claims for those *Services* will be denied and *You* will be responsible to pay for those *Services*.

3.7 MEDICAL COST MANAGEMENT

Coverage under this *Plan* is subject to the medical cost management protocols that are established *by Providence Health Plan* to ensure the quality and cost effectiveness of *Covered Services*. Such protocols may include *Prior Authorization*, concurrent review, case management and disease management.

PHP uses protected health information and may share it with others as part of Your treatment, payment for Your treatment and business operations. PHP may share Your information with Your Providers and Hospitals to help them provide medical care to You. For example, if You are in the Hospital, PHP may provide Hospital personnel involved in Your treatment access to any medical records sent to Us by Your Participating Providers.

PHP may use or share Your information with others to help manage Your health care. For example, PHP might talk to Your Participating Provider to suggest a disease management or wellness program that could improve Your health.

The *Plan* reserves the right to deny payment for *Services* that are not *Medically Necessary* in accordance with the criteria maintained by *PHP*. When more than one medically appropriate alternative is available, *PHP* will approve the least costly alternative.

Under its medical cost management protocols and the criteria specified in this paragraph, *PHP* may approve a substitution for a *Covered Service* under this *Plan*. A substituted *Service* must:

1. Be *Medically Necessary*;
2. Have *Your* knowledge and agreement while receiving the *Service*;
3. Be prescribed and approved by *Your* treating *Qualified Practitioner*; and
4. Offer a medical therapeutic value at least equal to the *Covered Service* that would otherwise be performed or given.

PHP may disallow a substituted *Service* at any time, at the sole discretion of *PHP*, by sending a 30-day advance written notice to *You* and *Your* treating physician/provider.

3.8 HOW BENEFITS ARE APPLIED

Benefits are subject to the following *Plan* provisions, if applicable, as specified in the *Summary of Benefits*:

1. The *Copayment* or *Coinsurance* amount; and
2. The benefit limits and/or maximums.

4. ELIGIBILITY AND ENROLLMENT

This section outlines who is eligible for coverage and the related enrollment procedures that apply to *Eligible PEBB Members* and *Eligible Family Dependents*. *Plan* benefits shall not be available to anyone who is not properly enrolled in this *Plan*.

There will be an *Annual Group Enrollment Period* each *Year*. The *Effective Date of Coverage* for new *Participants* who enroll during the *Annual Group Enrollment Period* is the beginning of the *Year* for which they enroll.

4.1 PEBB MEMBER ELIGIBILITY AND ENROLLMENT

4.1.1 Eligibility, Effective Date, Enrollment

PEBB Members are eligible for coverage as specified in the eligibility or coverage continuation provisions established by *PEBB*. The *PEBB* eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the *PEBB* eligibility rules for detailed information on eligibility and program requirements.

4.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

4.2.1 Eligible Family Dependents, Eligibility Date

Eligible Family Dependent means a dependent of a *PEBB Member* who is eligible for coverage as specified in the eligibility or coverage continuation provisions established by *PEBB*. The *PEBB* eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the *PEBB* eligibility rules for detailed information on eligibility and program requirements.

4.2.3 Additional Requirements for Eligible Family Dependent Coverage

1. A PEBB Member may cover *Eligible Family Dependents* only if the *PEBB Member* is also covered.
2. A covered *Dependent* child who becomes a *PEBB Member* by virtue of his/her employment is no longer an *Eligible Family Dependent*.

4.2.4 Eligible Family Dependent Enrollment

You must enroll *Eligible Family Dependents* in accordance with the requirements established by *PEBB*. No *Eligible Family Dependent* will become a *Participant* until *PEBB* approves that *Eligible Family Dependent* for coverage. The *PEBB* eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the *PEBB* eligibility rules for detailed information on eligibility and program requirements.

4.2.5 Newborn Eligibility and Enrollment

A newborn or adopted child of a *Participant* who meets the definition of an *Eligible Family Dependent* is eligible for enrollment from the date of birth or placement for the purpose of adoption. The *PEBB* eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the *PEBB* eligibility rules for detailed information on eligibility and program requirements.

4.3 SPECIAL ENROLLMENT PERIODS

If *You* declined enrollment for yourself as a *Participant* or for an *Eligible Family Dependent* during a previous enrollment period (as stated in sections 4.1 and 4.2*), You* may be eligible to enroll yourself or the *Eligible Family Dependent* during a "special enrollment period." The *PEBB* eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the *PEBB* eligibility rules for detailed information on eligibility and program requirements.

4.3.1 New Dependents

If *You* were eligible to enroll as a *Participant* in this *Plan*, but did not enroll during a previous enrollment period, and a person becomes *Your Eligible Family Dependent* through marriage, birth, adoption or placement for adoption; *You* may be eligible for a "special enrollment period" during which *You* and *Your Eligible Family Dependent(s)* may enroll in any of the medical plan options for which *You* are eligible. The *PEBB* eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the *PEBB* eligibility rules for detailed information on eligibility and program requirements.

4.4 LEAVE OF ABSENCE AND LAYOFF

The *PEBB* eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB Eligibility Handbook for detailed information on eligibility and program requirements.

5. COVERED SERVICES

This section describes *Medically Necessary Services* that are covered under this *Plan*.

Benefits for the treatment of illness or injury when such treatment is provided by a *Qualified Practitioner* include the *Covered Services* that are listed in this section and shown in the Medical *Summary of Benefits*. *Covered Services* for the diagnosis and treatment of *Mental Health* or *Chemical Dependency* are described under *Mental Health* and *Chemical Dependency* in section 6.2.

See section 6 (the Limitations section) for the specific coverage provisions that apply to these *Covered Services*:

- Human Organ/Tissue Transplants;
- Restoration of Head/Facial Structures and Limited Dental *Services*;
- Temporomandibular Joint (TMJ) *Services*; and
- Surgery and anesthesia for dental *Services*.

5.1 PROVIDER SERVICES

The following are *Covered Services*:

5.1.1 Office Visits, Inpatient and Outpatient Hospital Visits and Home Visits

Office visits, inpatient and outpatient *Hospital* visits and home visits with a *Qualified Practitioner* are covered as shown in the Medical *Summary of Benefits*. *Copayments* and *Coinsurances* as shown in the Medical *Summary of Benefits*, apply to all provider visits except those that: (a) are for conditions for which a separate and specific *Copayment* or *Coinsurance* amount is specified in this *Member Handbook*; or (b) are ancillary to the visit and are billed separately by the *Qualified Practitioner*.

5.1.2 E-visits

E-visits are covered as shown in the Medical *Summary of Benefits*.

Not all *Participating Providers* offer *E-visits*. Medical doctors (MD), Doctors of Osteopathy (DO), Nurse Practitioners (NP) and Physician Assistants (PA) are the only categories of providers approved for *E-visits*. *Participating Providers* who are authorized to provide *E-visits* have agreed to use appropriate Internet security technology to protect *Your* information from unauthorized access or release.

To be eligible for the *E-visit* benefit, *You* must have had at least one prior office visit with *Your Participating Provider* within the last twelve (12) months.

Covered *E-visits* include, but are not limited to:

- Communications of a new or existing diagnosis or treatment when the equivalent service received through an office visit would have led to a claims submission to be covered by *Us*;
- Communications by the *Participating Provider* about the management of complex chronic conditions that require extensive education and ongoing monitoring;
- Communications of treatment for relapses of a previous condition that involve extended dialogue and significant physician time and judgment;
- Discussion of lab results that require significant changes in medication or further testing; and
- Extended counseling when person-to-person contact would involve an unwise delay.

Examples of E-mail communications that do not qualify as *E-visits* include, but are not limited to:

- Renewing prescriptions;
- Scheduling tests;
- Scheduling appointments;
- Reporting normal test results;
- Recommending a referral to another physician;
- A consultative message exchange from a patient who is seen in-person immediately afterward as a result of the consultative message;
- A brief follow-up of an office visit, medical procedure or other treatment to confirm stable condition; and
- A brief discussion to confirm stability of a chronic problem and continuity of present management of the problem.
- All communications in connection with mental health or chemical dependency covered services.

5.1.3 Administration of Anesthesia and Surgical Procedures

Benefits include the administration of anesthesia and surgical procedures, including assistant surgeon and post-operative care.

5.2 PREVENTIVE SERVICES

The following are preventive *Covered Services* and are covered as shown in the Medical *Summary of Benefits*.

5.2.1 Physical Examinations and Well-Baby Care

Benefits for physical examinations and well-baby care for prevention and detection of disease are in accordance with the following schedule, or as recommended by *Your Medical Home Provider*. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 4.

Infants up to 24 months:	Up to 8 well baby visits.
Children:	
2 years through 6 years:	One exam every year.
7 years through 19 years:	One exam every 2 years.
Adults:	
20 years through 29 years:	One exam every 5 years.
30 years through 49 years:	One exam every 2 years.
50 years and older:	One exam every year.

Physical Exams for Commercial Driver's License: Coverage, limited to the *PEBB Member* only, is also provided for a physical examination required to obtain a commercial driver's license when that examination is performed by a *Medical Home Provider*. The *PEBB Member* must obtain a voucher from *PEBB* or the employing agency prior to the examination and the *Medical Home Provider* must submit the voucher with the claim.

5.2.2 Immunizations

Benefits for immunizations are provided in accordance with accepted medical practice and as shown in the Medical *Summary of Benefits*. Visits to *Your Medical Home Provider*'s office for immunizations or injections are covered in full. Immunizations provided by a non-participating provider will be subject to the coinsurance shown in the medical *Summary of Benefits*..

Covered Services do not include immunizations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs or college entrance. Immunizations are covered for the purpose of travel.

5.2.3 Annual Gynecological Examinations

Benefits for annual gynecological examinations include breast, pelvic and pap examinations once every calendar year, or more frequently for women designated high risk. Benefits also include follow-up exams for any medical conditions discovered during an annual gynecological exam that requires additional treatment.

5.2.4 Mammograms

Mammograms are covered on an annual basis for women over 40 years of age, or as recommended by the *Medical Home Provider* or *Women's Health Care Provider* for women with a designated high risk.

5.2.5 Family Planning Services

Benefits include consultation, IUD insertion and removal, diaphragms and Depo-Provera to prevent pregnancy. Removal of Norplant is included when determined to be *Medically Necessary*. Oral contraceptives (birth control pills) are covered and are subject to the terms and limitations of the prescription drug benefits of this *Plan*.

5.2.6 Prostate Cancer Screening Exams

Benefits for prostate cancer screening examinations include digital rectal examination and prostate-specific antigen test, biennially for men age 50 or older, or as recommended by the *Qualified Practitioner* for men designated high risk.

5.2.7 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations for member age 50 or older include:

- One fecal occult blood test per year plus one sigmoidoscopy every five years, or
- One colonoscopy every ten years, or
- One double contrast barium enema every five years.

Exams for *Members* considered high risk are covered as recommended by the *Qualified Practitioner*.

5.2.8 Preventive Services for Members with Diabetes

The following *Covered Services* apply to *Participants* diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus:

- Annual Exams: Dilated retinal exams by a qualified participating eye care specialist; glycosylated hemoglobin (HbAlc) test; urine test to test kidney function; blood test for lipid levels as appropriate; visual exam of mouth and teeth by a *Medical Home Provider* or other provider (dental visits are not covered); foot inspection; and influenza vaccine.
- Pneumococcal vaccines are provided every five years.

5.2.9 Nutritional Counseling

Nutritional counseling services are covered by the Plan and include *Medically Necessary* nutritional counseling services related to bariatric surgery, prior to and following the surgery. A maximum of two visits per calendar year are covered for nutritional counseling for weight-loss related diagnoses.

5.2.10 Hearing Exams and Hearing Aids

Hearing exams are covered as an office visit, as shown in the Medical *Summary of Benefits*. Hearing aids are covered at 90% of allowable expenses or billed charges for non-participating providers, up to a maximum of $4,000 per Member every four calendar years. The coinsurance you pay toward the cost of the hearing aids does not accumulate toward the annual out-of-pocket maximum.

5.3 HOSPITAL AND SKILLED NURSING FACILITY SERVICES

A *Copayment* or *Coinsurance*, whichever is applicable, will be applied once per *Confinement*, even if *You* are treated in more than one *Hospital* and/or *Skilled Nursing Facility*.

Covered Services do NOT include care received that consists primarily of:

1. Room and board and supervisory or custodial *Services*.
2. Personal hygiene and other forms of self-care.
3. Non-skilled care for senile deterioration, mental deficiency, or developmental disability.

In all cases the following are specifically excluded from the *Hospital* and *Skilled Nursing Facility* benefit:

1. Private duty nursing or a private room unless prescribed as *Medically Necessary*.
2. Take-home medications, supplies and equipment.
3. Personal items such as telephone, radio, television and guest meals.

5.3.1 Hospital Services

Benefits are provided as shown in the Medical *Summary of Benefits* and include *Services* for semiprivate room accommodations, coronary care and intensive care. Other *Hospital Covered Services* include, but are not limited to, use of the operating room, anesthesia, dressings, medications, oxygen, x-rays, and laboratory services during the period of inpatient hospitalization.

If benefits under this plan change while you or an enrolled dependent is in the hospital, covered expenses will be based on the benefit in effect when the stay began.

5.3.2 Skilled Nursing Facility

Benefits are provided as shown in the Medical *Summary of Benefits* for *Covered Services* from a *Skilled Nursing Facility*. *Services* must be *Prior Authorized* by *PHP* and prescribed by *Your Qualified Practitioner* in order to limit *Hospital Confinement* by providing convalescent skilled medical and nursing *Services* which cannot be adequately provided through a home health program.

5.3.3 Inpatient Rehabilitation Services

Benefits are provided, as shown in the Medical *Summary of Benefits*, for *Medically Necessary* inpatient rehabilitation to restore or improve lost function following illness or injury. If a *Participant* is hospitalized when rehabilitative *Services* begin, rehabilitative benefits will begin on the day treatment becomes primarily rehabilitative.

5.4 MENTAL HEALTH SERVICES

Benefits are provided for *Mental Health Services* at the same level as and subject to limitations no more restrictive than those imposed on coverage or reimbursement for *Medically Necessary* treatment for other medical conditions.

Covered Services include diagnostic evaluation, individual and group therapy; inpatient hospitalization as stated in section 5.3; and residential and day or partial hospitalization *Services*. All inpatient, residential and day or partial hospitalization treatment *Services* must be *Prior Authorized* as specified in section 4.7.

In an emergency situation, go directly to a *Hospital* emergency room. *You* do not need *Prior Authorization* for emergency treatment; however, *We* must be notified within forty-eight (48) hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

5.5 CHEMICAL DEPENDENCY SERVICES

Benefits are provided for *Chemical Dependency Services* at the same level as and subject to limitations no more restrictive than those imposed on coverage or reimbursement for *Medically Necessary* treatment for other medical conditions.

Covered Services include diagnostic evaluation, detoxification, individual and group therapy; inpatient hospitalization as stated in section 5.3; and residential and day or partial hospitalization *Services* when they:

- Meet the "American Society of Addiction Medicine Placement Guidelines for Substance Related Disorders" (ASAM) criteria; and
- For all inpatient, residential and day or partial hospitalization treatment *Services*, are *Prior Authorized* as specified in section 4.7.

Treatments involving the use of Methadone are a *Covered Service* only when such treatment is part of a medically-supervised treatment program that has been *Prior Authorized*.

In an emergency situation, go directly to a *Hospital* emergency room. *You* do not need *Prior Authorization* for emergency treatment; however, *We* must be notified within forty-eight (48) hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

5.6 OUTPATIENT HOSPITAL SERVICES, DIALYSIS, CHEMOTHERAPY, RADIATION THERAPY

Benefits are provided as shown in the Other Covered Services section of the Medical *Summary of Benefits* and include outpatient *Services* at a *Hospital* or *Outpatient Surgical Facility*, dialysis, chemotherapy and radiation therapy. See section 5.7.2 regarding injectable medications. *Covered Services* include, but are not limited to, *Services* for a surgical procedure and regularly scheduled therapy such as chemotherapy, inhalation therapy, or radiation therapy as ordered by *Your Qualified Practitioner.*

Covered Services under these benefits do not include *Services* for Short-Term Outpatient Rehabilitation. Please refer to those specific *Services* within section 5.7.12.

5.7 EMERGENCY CARE SERVICES

Benefits for *Emergency Services* are provided as described below and shown in the Medical *Summary of Benefits*. For further information regarding obtaining *Emergency Services*, please see section 3.4 of this *Member Handbook*.

5.7.1 Emergency Care

Coverage is provided without *Prior Authorization* for *Emergency Medical Screening Exams* and stabilization of an *Emergency Medical Condition*. *Hospitalization* for an *Emergency Medical Condition* requires notification to *PHP* within 48 hours, or as soon as reasonably possible following the onset of treatment, in order for coverage to continue.

Maternity *Services* provided for an unexpected delivery outside of the *Service Area* are covered at the Out-of-Plan level.

Covered Services do **NOT** include *Services* for the inappropriate (non-emergency) use of an emergency room. This means *Services* which could be delayed until *You* can be seen in *Your Qualified Practitioner's* office, for example: treatment of minor illnesses such as flu or sore throat, check ups, follow-up visits and prescription drug requests.

5.7.2 Emergency Medical Transportation

Benefits include *Services* for emergency medical transportation by state certified ambulance and certified air ambulance transportation when *Medically Necessary*. Air ambulance transportation must be *Prior Authorized* by *PHP* except when used for medical emergencies. Out-of-area ambulance *Services* are provided for transportation to the nearest facility capable of providing the necessary care or to a facility specified by *PHP*.

5.7.3 Emergency Eye Care Services

Covered Services include the initial care for *Emergency Medical Conditions* resulting from an injury to or illness of the eye(s). *Participants* may receive *Services* directly from an optometrist or ophthalmologist or a hospital emergency room.

5.8 URGENT/IMMEDIATE CARE SERVICES

Benefits include *Services* from an *Urgent/Immediate Care* facility or other provider and are provided as shown in the Medical *Summary of Benefits*. For further information regarding use of *Urgent/Immediate Care Services*, please see the How to Use Your Plan section of this *Plan*. *Urgent/Immediate Care Services* do not include the care of an *Emergency Medical Condition*.

5.9 OTHER COVERED SERVICES

The following are other *Covered Services* and are provided as shown in the Medical *Summary of Benefits*.

5.9.1 Maternity Services & Newborn Nursery Care

Benefits include prenatal care, delivery and postnatal care. In accordance with federal and state requirements, coverage of inpatient delivery *Services* will not be less than 48 hours for normal vaginal deliveries and 96 hours for cesarean section deliveries, unless the mother and treating physician determine than an earlier discharge is appropriate. See section 5.9.5 for a description of covered diagnostic x-ray and laboratory tests. Maternity *Services* for a *Participant* who is serving as a surrogate parent are covered, except to the extent that such *Services* are payable under the surrogate parenting contract or agreement.

We cover routine nursery care of a well-newborn under the newborn's own coverage. However, this benefit does not cover professional provider charges for well-baby care except as may be specifically provided under other provisions of the plan, nor does it cover pediatric standby charges for a vaginal delivery.

Please note: Benefits for covered expenses of an ill or injured newborn are paid under other provisions of this plan.

If benefits under this plan change while you or an enrolled dependent is in the hospital, covered expenses will be based on the benefit in effect when the stay began.

5.9.2 Allergy Shots, Allergy Serums and Injectable Medications

Allergy shots, allergy serum, injectable medications and total parenteral nutrition (TPN) are covered as shown in the Medical *Summary of Benefits*. Therapy and testing for treatment of allergies including, but not limited to, *Services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or

testing is approved by The American Academy of Allergy and Immunology, or The Department of Health and Human Services or any of its offices or agencies.

5.9.3 Reconstructive Surgery

Reconstructive Surgery is covered for conditions resulting from trauma, infection or other diseases and for congenital deformities and anomalies if there is a resultant functional impairment. Benefits are covered as those *Services* listed in the Medical *Summary of Benefits* based upon the type of *Services* received. All *Covered Services* for Reconstructive Surgery must be *Prior Authorized*.

5.9.4 Diabetes Self-Management Education Program

Benefits are paid in full for initial self-management education programs obtained at a participating facility.

5.9.5 Diagnostic Pathology, Radiology Tests and Diagnostic Procedures

Benefits are as shown in the Medical *Summary of Benefits* and include inpatient and outpatient diagnostic pathology (lab), radiology (x-ray) tests and other *Medically Necessary* diagnostic procedures. *Covered Services* include contrast materials (dyes) that may be required for a diagnostic procedure.

5.9.6 Home Health Care Benefit

Benefits for home health care *Covered Services* are shown in the Medical *Summary of Benefits* and are described below. A *Home Health Provider* must provide *Services* at *Your* home under a home health care plan. Nothing in this provision will increase benefits to cover home health care *Services* that are not otherwise covered under this *Plan*.

Each visit by a person providing *Services* under a home health care plan or evaluating the need for or developing a plan is considered one home health care visit. Up to four (4) consecutive hours in a 24-hour period of home health care *Service* is considered one home health care visit. A home health care visit of more than four (4) hours is considered one visit for every four (4) hours or part thereof.

Home health care will not be reimbursed unless *Your Qualified Practitioner* certifies that:

1. The home health care *Services* will be provided or coordinated by a state-licensed or Medicare-certified Home Health Agency or certified rehabilitation agency; and
2. *PHP* determines the *Services* to be *Medically Necessary*.

If *You* were hospitalized immediately prior to the commencement of home health care, the home health care plan must be initially approved by the *Qualified Practitioner* who was the primary provider of *Services* during the hospitalization.

If the above criteria are not met, **NO** benefits will be provided under this *Plan* for home health care.

Rehabilitation *Services* provided under an authorized home health care plan will be covered as home health care *Services*.

Home health care benefits do **NOT** include:

1. Charges for mileage or travel time to and from *Your* home;
2. Wage or shift differentials for *Home Health Providers*;
3. Charges for supervision of *Home Health Providers*; or

4. *Services* that consist principally of *Custodial Care* including, but not limited to, care for senile deterioration, mental deficiency, mental retardation or mental illness, or care of a chronic or congenital condition on a long-term basis.

5.9.7 Hospice Care Benefit

Benefits are included for hospice care as shown in the Medical *Summary of Benefits* and described below. In addition, the following criteria must be met:

1. *You* obtain *Prior Authorization* from *PHP*;
2. *PHP* determines the *Services* to be *Medically Necessary*;
3. *Your Qualified Practitioner* certifies that *You* have a terminal illness with a life expectancy not exceeding six (6) months; and
4. The *Covered Services* provided are reasonable and necessary for the condition and symptoms being treated.

When the above criteria are met, the *Plan* will provide benefits for a full range of *Covered Services* which a certified hospice care program is required to include. *Covered Services* include the following:

1. Nursing care provided by or under the supervision of a registered nurse;
2. Medical social services provided by a medical social worker who is working under the direction of a physician, including counseling for the purpose of helping *You* and *Your* caregivers adjust to the approaching death;
3. *Services* provided by *Your Qualified Practitioner* or a physician associated with the hospice program;
4. *Durable Medical Equipment*, medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness;
5. Home health aide *Services* for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care;
6. Rehabilitation therapies provided for purposes of symptom control or to enable *You* to maintain activities of daily living and basic functional skills; and
7. Continuous home care during a period of crisis in which *You* require skilled intervention to achieve palliation or management of acute medical symptoms.

Respite care and other *Services* not specified above are excluded from coverage.

5.9.8 Inborn Errors of Metabolism

Benefits are provided for *Covered Services* as shown in the Medical *Summary of Benefits* based upon the type of *Services* received for diagnosing, monitoring and controlling inborn errors of metabolism, including PKU, that involve amino acid, carbohydrate and fat metabolism. *Covered Services* include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders

5.9.9 Medical Supplies/Devices, Prosthetic Devices and Durable Medical Equipment

Benefits for medical supplies/devices, prosthetic devices, and *Durable Medical Equipment (DME)* are provided as shown in the Medical *Summary of Benefits* when required for the standard treatment of illness of injury. *PHP* may authorize the purchase of an item if *they* determine the cost of purchasing an item would be less than the overall rental of the item. *Services* must be prescribed by *Your Qualified Practitioner.*

The reasonable cost of repairing an item is covered as long as this cost does not exceed the purchase of a new piece of equipment or device. Items that are replaced due to loss or negligence are not covered. Items that are replaced due to the availability of a newer or more efficient model are not covered unless *PHP* determines

otherwise. Repair or replacement is covered if due to normal growth processes or to a change in *Your* physical condition due to illness or injury.

Medical Supplies/Devices

Benefits are provided as shown in the Medical *Summary of Benefits* for medical supplies or devices that are described below.

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for *Participants* with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three (3) months from initial date of service unless there is clinical evidence of the need to continue.
4. Orthotics when required as a result of surgery, congenital defect or diabetes limited to a maximum benefit of $200 every calendar year. Orthotics do not include prosthetic devices or childhood braces.
5. Other *Medically Necessary* supplies as ordered by *Your Qualified Practitioner*, including, but not limited to, ostomy supplies, IUD's, diaphragms, prescribed needles, syringes and chem strips. Non-sterile examination gloves used by *You* or *Your* caregiver are NOT a covered medical supply.
6. Diabetes supplies may be purchased through *PHP's* medical supply providers or at participating pharmacies.
7. Medical devices surgically implanted in a body cavity to replace or aid the function of an internal organ.
8. *Medically Necessary Medical Foods* for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be *Medically Necessary* for the treatment of severe intestinal malabsorption. Approval of these *Services* will be based on criteria established by *PHP* and in accordance with regulatory requirements.

   Medical Foods are defined as foods that are formulated to be consumed or administered enterally under strict medical supervision, for the treatment of inborn errors of metabolism including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency. Medical foods do not include total parenteral nutrition (TPN), which is covered as described in section 5.9.2.

Prosthetic Devices

Benefits are provided for prosthetic devices as shown in the Medical *Summary of Benefits*. *Covered Services* include prosthetic devices such as artificial limbs, breast implants inserted during reconstructive surgery following mastectomy, artificial eyes and maxillofacial prosthetic devices that are *Medically Necessary* for the restoration and management of head and facial structures.

Durable Medical Equipment (DME)

Benefits are provided for *DME* as shown in the Medical *Summary of Benefits*. *Covered Services* include *Medically Necessary* equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by *PHP*.

Covered Services for *DME* do not include items that are primarily and customarily used for a non-medical purpose or which are used for environmental control or enhancement (whether or not prescribed by a physician).

5.9.10 Podiatry/Foot Services

Benefits include *Covered Services* of a podiatrist or other *Qualified Practitioner* and are provided as shown in the Physician/Provider Services section of the Medical *Summary of Benefits*. Orthotics are covered as stated in section 5.7.9 for Medical Supplies/Devices. *Covered Services* do not include routine foot care and the removal of corns or calluses, unless *You* have diabetes.

5.9.11 Reconstructive Breast Surgery

Benefits for *Reconstructive Surgery* of the breast are covered as those *Services* listed in the Medical *Summary of Benefits* based upon the type of *Services* received and in accordance with the Women's Health and Cancer Rights Act of 1998. *Reconstructive Surgery* of the breast is covered for:

1. Reconstruction of the involved breast following a mastectomy;
2. Surgery and construction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of all stages of mastectomy, including lymphedemas.

5.9.12 Short-Term Outpatient Rehabilitation

Benefits are included for outpatient physical, occupational and speech therapy *Covered Services* provided by a physician or licensed/registered therapist, as shown in the Medical *Summary of Benefits*, to restore or improve lost function following illness or injury. Benefits are limited to *Covered Services* that can be expected to result in measurable improvement of a *Participant's* condition.

IMPORTANT NOTE: A visit is considered a treatment with one provider. For example, if a physical therapist and a speech therapist are seen on the same day at the same facility, the services will count as two visits as treatment has been received from two providers.

Covered Services under this benefit do **NOT** include:

1. Adjustments and manipulations of any spinal or bodily area, except as covered under the alternative care benefit described in section 6.4;
2. Exercise programs;
3. Rolfing, polarity therapy and similar therapies;
4. Growth and cognitive therapies, including sensory integration and treatment of developmental delay; and
5. Rehabilitation *Services* provided under an authorized home health care plan as specified in section 5.7.6.

5.9.13 Bariatric Surgery

In-Plan coverage for bariatric/gastric bypass surgery *Services* for morbid obesity is provided, as shown in the Medical *Summary of Benefits* for inpatient *Services*, in accordance with the medical policy and criteria established and maintained by *PEBB*. *Prior Authorization* is required for coverage of bariatric/gastric bypass surgery *Services*. Approved surgical procedures may include gastric bypass, gastric stapling, gastroplasty, and the Lap-Band adjustable gastric banding system.

The *PEBB* criteria require an extensive evaluation prior to surgery and a staged approach:

Stage 1 – Patient meets clinical criteria necessary to be selected for Stage 2:

- BMI equal to or greater than 35 with a diagnosis of diabetes; or BMI equal to or greater than 40 with any comorbid condition; or BMI equal to or greater than 50 with or without comorbid conditions.

Stage 2 – Patient completes a 6-month work up that includes:

- Dietary counseling and education;
- Medical and psychological evaluation; and

- A weight loss of greater than 5% during the 6-month work up period.

Stage 3 – Patient completes the final stage including:
- Compliance with Stage 2 and approval to proceed; and
- Surgery done in a Center of Excellence based on program criteria.

Program Selection Guidelines: The following guidelines are designed to limit mortality and morbidity and are based on those of local health plans and the American Society of Bariatric Surgery:
- Established bariatric surgery program with 5 years' experience and supervised by a Board certified surgeon.
- Significant patient morbidity must be less than 20%.
- Performed at least 100 bariatric procedures over the last 5 years.
- Overall mortality rate must be less than 2%.
- Average documented follow-up of patients must be greater than 5 years.
- Significant weight loss demonstrated in 75% of all patients over 5 years.
- Average of 30% excess body weight loss achieved and maintained.

5.9.15 Elective Sterilization Services

Coverage is provided, as shown in the Medical *Summary of Benefits*, for voluntary sterilization (vasectomy or tubal ligation). *Services* to reverse a prior sterilization procedure are not covered.

5.9.16 Termination of Pregnancy Services

Covered Services include elective termination of pregnancy. Claims are processed under a separate administrative agreement with Unified Life Insurance Company, as shown in section 8.

5.9.17 Tobacco Cessation Services

Participation in the Free & Clear tobacco cessation program is covered in full. This program addresses tobacco dependence through a clinically proven, comprehensive approach to tobacco cessation that treats all three aspects of tobacco use – physical addiction, psychological dependence and behavioral patterns. An expert Quit Coach will create a quit plan for each program participant that includes:

- One-on-one phone based treatment sessions;
- Unlimited toll-free telephone access to Quit Coaches;
- A Quit Kit of materials designed to help program participants quit tobacco use through active self-management;
- Recommendations on and direct fulfillment of nicotine replacement therapy, if appropriate; and
- Information and decision support for bupropion, if appropriate.

Free & Clear can be reached at 1-866-QUIT-4-LIFE (784-8454), 5 a.m. through 9 p.m. (Pacific Time), seven days a week.

6. LIMITATIONS FOR SPECIFIED COVERED SERVICES

There are limitations on the benefits available under this *Plan* for the treatment of certain conditions and the use of certain procedures. These limitations are described in this section.

6.1 HUMAN ORGAN/TISSUE TRANSPLANTS

A transplant is defined as a procedure or series of procedures by which an organ or tissue is either;

- Removed from the body of one person (the donor) and implanted in the body of another person (the recipient who is a *Participant*); or
- Removed from and replaced in the same person's body (a self-donor who is a *Participant*).

The term transplant does not include *Services* related to the transfusion of blood or blood derivatives (except hematopoietic stem cells) or replacement of a cornea.

6.1.1 Covered Services (see also the Exclusion Period in section 6.1.7)

Covered Services for transplants are limited to *Services* that:

1. Are *Prior Authorized* and determined by *PHP* to be *Medically Necessary* and medically appropriate according to national standards of care;
2. Are provided at a facility approved by *PHP* or under contract with *PHP* **(Transplant *Services* are not covered Out-of-Plan)**;
3. Involve one or more of the following organs or tissues:
   - Heart
   - Lung
   - Liver
   - Kidney
   - Pancreas
   - Small bowel
   - Autologous hematopoietic stem cell / bone marrow
   - Allogeneic hematopoietic stem cell / bone marrow; and
4. Are directly related to the transplant procedure, including *Services* that occur before, during and after the transplant procedure.

Covered Services for transplant recipients include medical *Services, Hospital Services*, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per diem expenses apply to the $5,000 travel expenses benefit maximum.

Services for donors are covered when the donor is not eligible for coverage of donation *Services* under any other *Health Benefit Plan* or government funding program. *Covered Services* for donors include:

1. Initial evaluation of the donor and related program administration costs;
2. Preserving the organ or tissue;
3. Transporting the organ or tissue to the transplant site;
4. Acquisition charges for cadaver or live donor;
5. *Services* required to remove the organ or tissue from the donor; and

6. Treatment of medical complications directly resulting from the surgery performed to obtain the organ or tissue for a period of time not to exceed 30 consecutive days following that surgery.

6.1.2 Benefits for Donor Costs

Benefits for donor or self-donor costs are payable up to a maximum of $8,000 per covered transplant. Benefits are not payable if a donor is covered under this *Plan* and the recipient is not.

6.1.3 Benefits for Transplant Facility Services Provided to the Organ Recipient

The *Coinsurance* or *Copayment* provisions of this *Plan* are waived, except as follows:

- The *Participant*/recipient is responsible for the *Coinsurance* or *Copayment* amounts, as shown in the Medical *Summary of Benefits,* for inpatient *Hospital Services* and for outpatient facility *Services* that are not billed as a global fee and those amounts will apply to the *Participant's Out-of-Pocket Maximum*.

6.1.4 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related *Services*, including anti-rejection (immunosuppressive) drugs, are covered under the outpatient prescription drug benefits of this *Plan*, as specified in section 15.

6.1.5 Benefits for Physician/Provider Services Provided to the Organ Recipient

Benefits for physician/provider *Services* are provided as shown in the Medical *Summary of Benefits*. The *participant*/recipient is responsible for the *Coinsurance* or *Copayment* amounts for those *Services*, as shown in the Medical *Summary of Benefits*, unless those *Services* are billed as a global fee with the facility *Services*, and those amounts will apply to the *Participant's Out-of-Pocket Maximum*.

6.1.6 Prior Authorization (see also section 3.6)

To qualify for coverage under this *Plan*, all transplant related *Services*, procedures, treatment protocols and facilities must be *Prior Authorized*, including:

- Initial consultation;
- Evaluation;
- Transplant facilities;
- Donor evaluation;
- Donor *Services*;
- HLA typing;
- Travel expenses;
- Pre-transplant care;
- Self-donation *Services;*
- Transplant *Services*; and
- Follow-up treatment.

6.1.7 Exclusion Period

No benefits for human organ/tissue transplant *Covered Services* will be payable during the first 24 months that a *Participant* is covered under this *Plan* unless:

1. The *Participant* has been continuously covered under *Creditable Coverage* since birth or placement for adoption; or
2. The *Participant* has applicable *Creditable Coverage.* The duration of the 24-month *Exclusion Period* will be reduced by the amount of the *Participant's* prior *Creditable Coverage* if the most recent period of *Creditable Coverage* ended within 63 days of the *Effective Date of Coverage* under this *Plan*. However, *Creditable Coverage* will only be applied to human organ/tissue transplant *Covered Services* that were specified as

covered under the prior *Creditable Coverage*, regardless of the level of such prior coverage or the *Participant's* use of such prior coverage. The *Participant* is responsible for furnishing proof of *Creditable Coverage* and evidence of the terms of human organ/tissue transplant benefits under the previous coverage.

6.1.8 Exclusions

In addition to the exclusions listed in section 7 of this *Plan*, the following exclusions apply to human organ/tissue transplants:

- Any transplant procedure that has not been *Prior Authorized*;
- Any transplant procedure performed at a transplant facility that has not been approved by *PHP*;
- Any transplant that is *Experimental/Investigational*, as determined by *PHP*;
- *Services* or supplies for any transplant that are not specified as *Covered Services* in this section 6.1, such as transplantation of animal organs or artificial organs;
- High-dose chemotherapy administered prior to a transplant, unless those *Services* have been *Prior Authorized*;
- *Services* related to organ/tissue donation by a *Participant* if the recipient is not a *Participant* or the *Participant*/recipient is not eligible for transplant benefits under this *Plan*; and
- Transplant-related travel expenses for the donor and the donor's and recipient's family members.

6.2 RESTORATION OF HEAD/FACIAL STRUCTURES; LIMITED DENTAL SERVICES

Covered Services include restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or development deformities, when *Services* are medically necessary for the purpose of controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing.

Benefits are covered as those Services listed in the Medical *Summary of Benefits* based upon the type of *Services* received.

Limitations that apply to *Covered Services* include:

- All treatment, except *Emergency Services* must be *Prior Authorized*; and
- Conditions related to trauma must be diagnosed within six months of injury and treatment must begin within twelve months of the injury.

Exclusions that apply to *Covered Services* include:

- *Cosmetic Services*;
- *Services* rendered to improve a condition that falls within the normal range of such conditions;
- Orthodontia;
- *Services* to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;
- Removal of impacted teeth;
- The making or repairing of dentures;
- Orthognathic surgery to shorten or lengthen the upper or lower jaw, unless related to a traumatic injury or to a neoplastic or degenerative disease; and
- *Services* to treat temporomandibular joint syndrome except as specified in the following section of this *Member Handbook*.

6.2.1 Temporomandibular Joint (TMJ) Services

Benefits are provided for TMJ *Services* from a *Participating Provider* as shown in the Medical *Summary of Benefits.* All *Covered Services* for TMJ must be *Prior Authorized*. Covered *Services* include:

1. A diagnostic examination including a history, physical examination and range of motion measurements, as necessary;
2. Diagnostic x-rays;
3. Physical therapy of necessary frequency and duration, limited to 20 visits per calendar year;
4. Therapeutic injections;
5. Therapy utilizing an appliance/splint which does not permanently alter tooth position, jaw position or bite. Benefits for this therapy will be based on the use of a single appliance/splint, regardless of the number of appliances/splints used in treatment. Coverage of the appliance/splint is under the provisions of this section and coverage is not applicable under section 5.9.9 (Medical Supplies/Devices). The benefit for the appliance splint therapy will include an allowance for diagnostic *Services*, office visits and adjustments; and
6. Surgical *Services*

TMJ *Services* are not covered Out-of-Plan. *Covered Services* for TMJ conditions do not include dental or orthodontia *Services*.

6.2.2 Outpatient Hospitalization and Anesthesia for Dental Services

Benefits for outpatient hospitalization and anesthesia for dental *Services* are covered as those *Services* listed in the Medical *Summary of Benefits* based upon the type of *Services* received. *Services* must be *Prior Authorized* and will only be provided for *Participants* with complicating medical conditions. Examples of these conditions include, but are not limited to:

- Developmental disabilities;
- Physical disabilities; or
- A combination of medical conditions or disabilities which cannot be managed safely and efficiently in a dental office.

Dental *Services* are excluded.

6.3 INFERTILITY SERVICES

Coverage for infertility *Services* is provided, as shown in the Medical *Summary of Benefits* for other office procedures, when a diagnosis of infertility has been established. Infertility is defined as the inability to become pregnant after a year of unprotected intercourse or the inability to carry a pregnancy to term as evidenced by three (3) consecutive spontaneous miscarriages.

Covered Services include the following:

1. Diagnostic testing and associated office visits to determine the cause of infertility. This includes the physical examination, related laboratory testing, instruction, and medical/surgical procedures when preformed for the sole purpose of diagnosing and treating an infertile state. Diagnostic *Services* for the treatment of infertility include, but are not limited to hysterosalpingogram, laparoscopy and pelvic ultrasound.
2. Artificial insemination, limited to maximum of six (6) cycles and sperm wash;
3. Cost of acquiring semen;
4. Infertility related drugs or injectables; and
5. Covered infertility-related supplies.

Covered Services do NOT include:

1. Charges for donor semen from donor banks or other providers;
2. Charges for harvesting and storage of semen other than for immediate use;
3. Infertility *Services* not resulting from a medical condition;
4. All *Services* for non-*Participant* surrogate mothers; and
5. Infertility resulting from the aging process as confirmed by elevated FSH.
6. In vitro and in vivo fertilization including services related to or supporting in vitro fertilization, GIFT, ZIFT, reversals of voluntary sterilization and procedures determined to be experimental or investigational.

Expenses for infertility services do not accumulate toward the annual out-of-pocket maximum.

6.4 ALTERNATIVE CARE

Services from the following alternative care providers are covered as shown in the Medical *Summary of Benefits* when the *Service* is *Medically Necessary* and within the licensed scope of practice of the provider involved:

- Acupuncturists;
- Naturopathic Physicians; and
- Chiropractors.

Please note that benefits are limited as noted in the Summary of Benefits in section 2.

7. EXCLUSIONS

In addition to those *Services* listed as not covered in the Covered Services or Limitations sections, the following are specifically excluded from coverage under this *Plan*.

General Exclusions:

***We* do not cover *Services* and supplies which:**

- Are not provided;
- Are provided without charge or for which *You* would not be required to pay if *You* did not have this coverage;
- Are received before the *Effective Date of Coverage*;
- Are not a *Covered Service* or relate to complications resulting from a non-covered S*ervice;*
- Are not furnished by a *Qualified Practitioner* or *Qualified Treatment Facility*;
- Are provided by or payable under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while *You* are confined in a *Hospital* or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U. S. C. § 1729 as it relates to non-military *Service*s provided at a Veterans Administration *Hospital* or facility;
- Services provided while in the custody of any law enforcement authorities or while incarcerated.
- Are self-administered or provided by a person who ordinarily resides in *Your* home or who is a member of *Your* immediate family (parent, spouse, domestic partner, sibling or child);
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system and volunteer mutual support groups;
- Are performed in association with a *Service* that is not covered under this *Plan;*
- Are provided for any injury or illness that is sustained by a *PEBB Member* or a *Family Member* that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the *PEBB Member* or *Family Member*. This exclusion also applies to injuries and illnesses that are the subject of a disputed claim settlement under a Workers' Compensation Act or similar law. This exclusion does not apply to *Participants* who are exempt under any Workers' Compensation Act or similar law;
- Are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or S*ervices* available to *You*, whether or not *You* make application for such benefits or *Services*. Any benefits or S*ervices* provided under this *Plan* that are subject to this exclusion are provided solely to assist *You* and such assistance does not waive the *Plan's* right to reimbursement or subrogation as specified in section 8.2. This exclusion also applies to *Services* and supplies after *You* have received proceeds from a settlement as specified in section 8.2.3;
- Are provided in an institution that specializes in treatment of developmental disabilities;
- Are provided for treatment or testing required by a third party or court of law which is not *Medically Necessary*;
- Are *Experimental/Investigational*;
- Are determined by *Providence Health Plan* not to be *Medically Necessary* for diagnosis and treatment of an injury or illness;
- Relate to any condition determined by *PHP* to have been sustained as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the *Participant* requiring *Services*, whether or not such *Participant* is charged or convicted of a crime on account of such illegal engagement or act (for purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor under applicable law if such *participant* were convicted for the conduct). Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition); and

- Relate to a civil revolution, riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

Exclusions that apply to *Mental Health* and *Chemical Dependency Services*:

- Conditions that are not responsive to therapeutic management after a diagnosis is made by a physician who has treated or examined the patient, except when the treatment or *Service*s provided are effective in maintaining existing functionality or preventing a decline in functionality;
- Conditions that are specified as excluded in Section 16 in the definitions of *Mental Health* and *Chemical Dependency*;
- *Services* provided under a court order or as a condition of parole or probation or instead of incarceration which are not *Medically Necessary*;
- Personal growth *Service*s such as assertiveness training or consciousness raising;
- *Services* related to developmental disabilities, developmental delays or learning disabilities including, but not limited to, education *Services*. A learning disability is a condition where there is meaningful difference between a child's current academic function and the level expected for a child that age. Educational *Services* include, but are not limited to, language and speech training, reading, and psychological and visual integration training as defined by the American Academy of Pediatrics Policy Statement—"Learning Disabilities, Dyslexia and Vision: A Subject Review";
- School counseling and support *Services*, home-based behavioral management, household management training, peer support *Services*, recreation, tutor and mentor *Services*; independent living *Services*, therapeutic foster care, wraparound *Services*; emergency aid for household items and expenses; *Services* to improve economic stability, and interpretation *Services*;
- Evaluation or treatment for education, professional training, employment investigations, and fitness for duty evaluations;
- Community Care Facilities that provide twenty-four (24) hour non-medical residential care;
- Speech therapy, physical therapy and occupational therapy *Services* provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 5.3.3. and 5.9.12;
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a DSM-IV-TR diagnosis;
- Neurological *Services* and tests including, but not limited to EEGs; PET, CT and MRI imaging *Services*; and beam scans (except as provided in section 5.9.5);
- *Services* related to the treatment of sexual disorders, dysfunctions or addiction;
- Vocational, pastoral or spiritual counseling;
- Dance, poetry, music or art therapy, except as part of an approved treatment program; and
- Treatments that do not meet the national standards for *Mental Health/Chemical Dependency* professional practice;

Exclusions that apply to Provider *Services*:

- The following *Services* if they are provided by a *Non-Participating Provider*:
  - All Human Organ/Tissue Transplants (see section 6.1);
  - All Temporomandibular Joint (TMJ) *Services* (see section 6.3.1);
  - All *E-visit Services* (see section 5.1.2);
  - Bariatric Surgery and related services (see section 5.7.13); and

- Diabetic education (see section 5.9.4).
- *Services* of homeopaths or faith healers; and
- *Services* of lay midwives.

Exclusions that apply to <u>Reproductive *Services*</u>:

- All *Services* related to sexual disorders or dysfunctions regardless of gender, including all *Services* related to a sex-change operation, including evaluation, surgery and follow-up *Services*;
- Condoms and other over-the-counter birth control products; and
- Home births and all related *Services*.

Exclusions that apply to <u>Vision *Services*</u>:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to laser eye surgery, radial keratotomy, myopic keratomelelusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism;
- *Services* for routine eye exams and vision care, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in section 5.9.9; and
- Orthoptics and vision training.

Exclusions that apply to <u>Dental *Services*</u>:

- Oral surgery (non-dental or dental) or other dental *Services* (all procedures involving the teeth; wisdom teeth; areas surrounding the teeth), except as approved by *PHP* and described in the Limitations section;
- *Services* for temporomandibular joint syndrome (TMJ) and orthognathic surgery, except as approved by *PHP* and described in the Limitations section; and
- Dentures and orthodontia.

Exclusions that apply to <u>Foot Care *Services*</u>:

- Routine foot care, such as removal of corns and calluses, except for *Participants* with diabetes; and
- *Services* for insoles, arch supports, heel wedges, lifts and orthopedic shoes. *Covered Services* for orthotics are described within the Covered Services section under Medical Supplies/Devices.

Exclusions that apply to <u>Prescription Drugs, Medicines and Devices</u>:

- Any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.

Exclusions that apply to <u>Miscellaneous *Services* and Items</u>:

- *Custodial Care*;
- Transplants, except as described in the Limitations sections;
- *Services* for *Durable Medical Equipment (DME)*, Medical Supplies/Devices and Prosthetic Devices except as described in the Other Covered Service section;
- Charges for *Services* that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitation *Services*, except as provided in section 5.3.3 and 5.7.12;
- "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient. "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and treatment sessions by computer Internet service;
- Non-emergency medical transportation;

- Allergy shots and allergy serums, except as provided in section 5.7.2;
- *Services* for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in section 6.1 and with *PHP's Prior Authorization*;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Massage therapy;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements;
- *Services* for genetic testing are excluded, except for *Service*s to establish a diagnosis of a suspected congenital condition. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- *Services* for *Cosmetic Services* including supplies and drugs, except as approved by *PHP* and described in the Covered Services section;
- *Services* related to obtaining insurance, employment, licensure (except as specified in section 5.2.1) or school admission; *Services* solely for the purpose of participating in camps, sports activities or recreation programs; *Services* for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of *UCR*; and
- Air ambulance transportation for non-emergency situations unless *Prior Authorized* by *PHP*.
- Charges for missed appointments.

8. CLAIMS ADMINISTRATION

8.1 SUBMITTING CLAIMS

All *Participating Providers* and many *Non-Participating Providers* will bill *Providence Health Plan* for *You*. *You* may receive a bill for information purposes only that indicates, "Your insurance has been billed." In order to ensure the timely processing of claims, *You* are encouraged to submit a claim for treatment within 60 days of the date of service. The *Plan* will not pay claims received more than 12 months after the date of service. However, exceptions will be made if we receive documentation of *Your* legal incapacitation. The *Plan* will pay a covered expense to the provider, the *Participant*, or jointly to both. If the *Plan* mistakenly makes a payment to which a *Participant* is not entitled, the *Plan* may recover the payment.

Claims should be submitted to *PHP* at:
Providence Health Plan
P.O. Box 4447
Portland, OR 97208-4447
For claim questions, please call: 503-547-7500 (Portland area), 1-800-878-4445 (toll-free), 503-574-8702 (TTY Portland area), 1-888-244-6642 (TTY toll-free).

Claims for elective termination of pregnancy Services should be submitted to:
Unified Life Insurance Company
Attention: Claims
P.O. Box 530128
Livonia, MI 48153-0128
1-800-342-2641 (6AM – 4:30PM Pacific time)

Explanation of Benefits (EOB). You will receive an EOB from *PHP* after *Your* claim is processed. An EOB is not a bill. An EOB explains how *PHP* has processed your claim and it will assist you in determining *Your* financial responsibility for the services shown on the EOB. *Copayment* and *Coinsurance* amounts, services or amounts not covered and general information about *PHP's* processing of *Your* claim are explained on the EOB.

***Plan* Time Frames for Processing Claims.** If *Your* claim is denied under the *Plan*, *PHP* will send an EOB to *You* with an explanation of the denial within 30 days after *Your* claim is received. If *PHP* needs additional time to process *Your* claim for reasons beyond their control, *You* will be sent a notice of delay explaining those reasons within 30 days after your claim is received. *PHP* will then complete the processing and send an EOB to *You* within 45 days after *Your* claim is received. If *PHP* needs additional information from *You* to complete the processing of *Your* claim, the notice of delay will describe the information needed and *You* will have 45 days to submit the additional information. Once *PHP* receives the additional information, they will complete the processing of the claim within 15 days.

Claims Involving *Prior Authorization* (Pre-Service Claims)

- **For services that do not involve urgent medical conditions:** *PHP* will notify *Your* provider or *You* of their decision within 2 business days after the *Prior Authorization* request is received. If *PHP* needs additional time to process the request for reasons beyond their control, they will complete their review and notify *Your* provider or *You* of *their* decision within 7 days after they receive the request.
- **For services that involve urgent medical conditions:** *PHP* will notify *Your* provider or *You* of their decision within 24 hours after the *Prior Authorization* request is received. If *PHP* need additional information to complete their review, they will notify the requesting provider or *You* within 24 hours after the request is received. The requesting provider or *You* will then have 48 hours to submit the additional information. *PHP* will then complete their review and notify the requesting provider or *You* of their

decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.

Claims Involving Concurrent Care Decisions. If an ongoing course of treatment for *You* has been approved by *PHP* and they then determine through their medical cost management procedures to reduce or terminate that course of treatment, *You* will be provided with advance notice of that decision. *You* may request a reconsideration of that decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. *PHP* will then notify *You* of their reconsideration decision within 24 hours after *Your* request is received.

8.2 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when *You* have received *Services* for a condition for which one or more third parties may be responsible. "Third party" means any person other than *You* and *PEBB*, as the sponsor of this *Plan*, and includes any insurance carrier providing liability or other coverage potentially available to *You*. For example, uninsured or underinsured motorist coverage, no-fault medical payments (auto, homeowners or otherwise), or other insurance (including student plans) whether under *Your* policy or not, is subject to recovery by *PHP* as a third-party recovery. Failure by *You* to comply with the terms of this section will be a basis for *PHP* to deny any claims for benefits arising from the condition. In addition, *You* must execute and deliver to *PHP* or other parties any document requested which may be appropriate to secure the rights and obligations of *You* and the *Plan* under these provisions.

8.2.1 Third-Party Liability/Subrogation and How it Affects You

Third-party liability refers to claims that are in whole or in part the responsibility of someone besides this *Plan* or *You.* Examples of third party liability are motor vehicle accidents, workplace injury or illness, or any other situation involving injury or illness, including wrongful death, in which *You* or *Your* heirs, beneficiaries or relatives have a basis to bring a lawsuit or to make a claim for compensation against any person or for which *You* or *Your* heirs, beneficiaries or relatives may receive a settlement (for example, food poisoning or an injury from a defective product are examples of third-party liability). Once it has been established that the third party is responsible to pay and is capable of paying for the expenses for the *Services* caused by that third party, *We* will not provide benefits for the *Services* arising from the condition caused by that third party. Such benefits are specifically excluded from coverage under this *Plan*.

If *PHP* makes claim payments on *Your* behalf for which a third party is responsible, the *Plan* is entitled to be repaid promptly for those payments, directly out of any recovery from the third party, including any settlement, award, verdict, payment or other monetary recovery. "Subrogation" means that *PHP* may collect directly from the third party to the extent that the *Plan* has paid on *Your* behalf for third-party liabilities. Because the *Plan* has paid for *Your* injuries, the *Plan,* rather than *You,* is entitled to recover those expenses. Prior to accepting any settlement of *Your* claims against a third party, you must notify *PHP* in writing of any terms or conditions offered in settlement and must notify the third party of the *Plan's* interest in the settlement established by this provision.

To the maximum extent permitted by law, the *Plan* is subrogated to *Your* rights against any third party who is responsible for the condition, has the right to sue any such third party in *Your* name, and has a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the *Plan* and for *PHP's* expenses in obtaining a recovery. If *You* should either decline to pursue a claim against a third party that *PHP* believes is warranted or refuse to cooperate with *PHP* in any third party claim that you do pursue, *PHP* has the right, on behalf of the *Plan*, to pursue such claim directly, including commencing a legal action against such third party or intervening in any action that *You* have commenced.

PHP needs detailed information from *You* to accomplish this process. A questionnaire will be sent to *You* for this information. It should be completed and returned to *PHP* as soon as possible to minimize any claim review

delay. If *You* have any questions or concerns regarding the questionnaire, please contact *PHP*. A *PHP* employee who specializes in third-party liability/subrogation can discuss with *You* what their procedures are and what *You* need to do.

8.2.2 Proceeds of Settlement or Recovery

If for any reason PHP is not paid directly by the third party, PHP is entitled to reimbursement from You or Your heirs, legal representatives, beneficiaries or relatives, and PHP may request refunds from the medical providers who treated You, in which case those providers will bill you for their Services. To the fullest extent permitted by law, the *Plan* is entitled to the proceeds of any settlement or any judgment that results in a recovery from a third party, whether or not responsibility is accepted or denied by the third-party for the condition, whether or not such monetary recovery is described by any person as something other than a recovery of medical expenses incurred by the Plan and whether or not You are alleged to have any fault, under principles of comparative negligence or otherwise. With respect to any workers' compensation recovery, we are entitled to the proceeds whether or not the loss is deemed to be compensable under the worker's compensation laws. . The *Plan* is entitled up to the full value of the benefits provided by it for the condition, calculated using *PHP's UCR* charges for such *Services*, less the *Participant's* out-of-pocket expenses and attorney fees incurred in making the recovery. The Plan is entitled to such recovery regardless of whether You have been fully compensated or "made whole" for the loss caused thy the third party, and regardless of whether You have been partially compensated for such loss. The Plan is entitled to first priority in repayment, over You and over any other person, for such charges.

By accepting benefits under this Plan, You acknowledge the Plan's first priority to this repayment and assign to the Plan any benefits You may have from other sources. *You* must cooperate fully with *PHP* in recovering amounts paid by the *Plan*. If *You* seek damages against the third party for the condition and retain an attorney or other agent for representation in the matter, *You* agree to require *Your* attorney or agent to reimburse the *Plan* directly from the settlement or recovery in the amount provided by this section..

You must complete *PHP's* subrogation trust agreement by which *You* and/or *Your* attorney or agent must confirms the obligation to reimburse the *Plan* directly from any settlement or recovery. *We* may withhold benefits for *Your* condition until a signed copy of this agreement is delivered to PHP. The agreement must remain in effect and *PHP* may withhold payment of benefits if, at any time, *Your* confirmation of the obligations under this section should be revoked. While this document is not necessary for *PHP* to exercise the *Plan's* rights under this section, it serves as a reminder to You and directly obligates Your attorney to act in accord with the *Plan's* rights.

8.2.3 Suspension of Benefits and Reimbursement

After *You* have received proceeds of a settlement or recovery from the third party, *You* are responsible for payment of all medical expenses for the continuing treatment of the illness or injury that the *Plan* would otherwise be required to pay until all proceeds from the settlement or recovery have been exhausted. If You have failed to reimburse the Plan as required by this section, the Plan is entitled to offset future benefit otherwise payable under the Plan or under any future Plan sponsored by PEBB, to the extent of the value of the benefits advanced under this section.

If *You* continue to receive medical treatment for the condition after obtaining a settlement or recovery from one or more third parties, the *Plan* is not required to provide coverage for continuing treatment until *You* prove to *PHP's* satisfaction that the total cost of the treatment is more than the amount received in settlement or recovered from the third party, after deducting the cost of obtaining the settlement or recovery. The *Plan* will only cover the amount by which the total cost of benefits that would otherwise be covered under this *Plan*, calculated using *PHP's UCR* charges for such services, exceeds the amount received in settlement or recovery from the third party. The *Plan* is entitled to suspend such benefits even if the total amount of such settlement or

recovery does not fully compensate *You* for other damages, particularly including lost wages or pain and suffering.

Any settlement arising out of an injury or illness covered by this *Plan* will be deemed first to compensate *You* for *Your* medical expenses, regardless of any allocation of proceeds in any settlement document that *PHP* has not approved in advance. In no event shall the amount reimbursed to the *Plan* be less than the maximum permitted by law.

8.3 COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) section applies when *You* or a *Family Member* has health care coverage under more than one *Plan*. The term "*Plan*" is defined below for the purposes of this COB section. The order of benefit determination rules govern the order in which each *Plan* will pay a claim for benefits. The *Plan* that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another *Plan* may cover some expenses. The *Plan* that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total Allowable expense.

If *You* have more than one insurance plan, obtaining *Services* under this *Plan* may be affected. Please contact *Your PHP* customer service team for more information or assistance.

8.3.1 Definitions Relating to Coordination of Benefits

Plan

Plan means any of the following that provides benefits or *Services* for medical or dental care treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage listed under (1) or (2) above is a separate *Plan*. If a *Plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *Plan*.

This plan

This *Plan* means, as used in this COB section, the part of this contract to which this COB section applies and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from this *Plan*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules listed in section 8.2.2 determine whether this *Plan* is a Primary plan or Secondary plan when *You* or a *Family Member* has health care coverage under more than one *Plan*.

When this *Plan* is primary, *PHP* determines payment for benefits first before those of any other plan without considering any other plan's benefits. When this *Plan* is secondary, *PHP* determines benefits after those of

another plan and may reduce the benefits paid so that all *Plan* benefits do not exceed 100% of the total Allowable expense.

Allowable expense

Allowable expense means a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering *You* or a *Family Member*. When a plan provides benefits in the form of *Services*, the reasonable cash value of each *Service* will be considered an Allowable expense and a benefit paid. An expense that is not covered by any plan covering *You* or *a Family Member* is not an Allowable expense. In addition, any expense for which a provider by law or in accordance with a contractual agreement is prohibited from charging is not an Allowable expense.

The following are examples of expenses that are NOT Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the plans provides coverage for private hospital room expenses.

2. If *You* or a *Family Member* are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If *You* or a *Family Member* are covered by two or more plans that provide benefits or *Services* on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. If *You* or a *Family Member* are covered by one plan that calculates its benefits or *Services* on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or *Services* on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all plans. However, if the provider has contracted with the Secondary plan to provide the benefit or *Service* for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

5. The amount of any benefit reduction by the Primary plan because *You* or a *Family Member* have failed to comply with the *Plan* provisions is not an Allowable expense. Examples of these types of *Plan* provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed panel plan

A Closed panel plan is a *Plan* that provides health care benefits to *Members* primarily in the form of *Services* through a panel of providers that have contracted with or are employed by the *Plan*, and that excludes coverage for *Services* provided by other providers, except in cases of emergency or referral by a panel member.

Custodial parent

A Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the *Dependent* child resides more than one half of the calendar year excluding any temporary visitation.

8.3.2 Priority Between Plans

When a *You* or a *Family Member* is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other *Plan*.

B.

1. Except as provided in Paragraph (2) below, a *Plan* that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both plans state that the complying plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A *Plan* may consider the benefits paid or provided by another *Plan* in calculating payment of its benefits only when it is secondary to that other *Plan*.

D. Each *Plan* determines its order of benefits using the first of the following rules that apply:

1. Non-*Dependent* or *Dependent*. The *Plan* that covers a *Family Member* other than as a *Dependent*, for example as a *PEBB Member* is the Primary plan and the *Plan* that covers the *Family Member* as a *Dependent* is the Secondary plan. However, if the *Family Member* is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the *Family Member* as a *Dependent*; and primary to the *plan* covering the *Family Member* as other than a *Dependent* (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the *Plan* covering the *Family Member* as an employee, subscriber or retiree is the Secondary plan and the other *Plan* is the Primary plan.

2. *Dependent* Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a *Family Member* is a *Dependent* child and is covered by more than one *Plan* the order of benefits is determined as follows:

a) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:

i. The *Plan* of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
ii. If both parents have the same birthday, the *Plan* that has covered the parent the longest is the Primary plan.

b) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the *Dependent* child's health care expenses or health care coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to plan years commencing after the *Plan* is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the *Dependent* child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the *Dependent* child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

iv. If there is no court decree allocating responsibility for the *Dependent* child's health care expenses or health care coverage, the order of benefits for the *Dependent* child are as follows:

- The *Plan* covering the Custodial parent, first;
- The *Plan* covering the spouse of the Custodial parent, second;
- The *Plan* covering the non-custodial parent, third; and then
- The *Plan* covering the *Dependent* spouse of the non-custodial parent, last.

c) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the *Dependent* child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the *Dependent* child.

3. PEBB Member or Retired or Laid-off Employee. The *Plan* that covers a *PEBB Member* as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The *Plan* covering that same *PEBB Member* as a retired or laid-off employee is the Secondary plan. The same would hold true if a *PEBB Member* is a *Dependent* of an active employee and that same person is a *Dependent* of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a *PEBB Member* or *Family Member* whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the *Plan* providing coverage as an employee, subscriber or retiree or as a *Dependent* of an employee, *Subscriber* or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The *Plan* that covered the *PEBB Member* as an employee, *Subscriber* or retiree longer is the Primary plan and the *Plan* that provided coverage for the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the *Plan*s meeting the definition of *Plan*. In addition, this *Plan* will not pay more than would have paid had it been the Primary plan.

8.3.3 Effect on the Benefits of This Plan

When this *Plan* is secondary, benefits may be reduce so that the total benefits paid or provided by all plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its *Plan* that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If *You* or a *Family Member* is enrolled in two or more Closed panel plans and if, for any reason, including the provision of *Services* by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that *Plan* and other Closed panel plans.

8.3.4 Right to Receive and Release Necessary Information

Certain facts about health care coverage and *Services* are needed to apply this COB section and to determine benefits payable under this *Plan* and other *Plans*. *PHP* may get the facts needed from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under this *Plan* and other *Plan*s covering *You* or a *Family Member* claiming benefits. *PHP* need not tell, or get the consent of, any person to do this. Each individual claiming benefits under this *Plan* must give *PHP* any facts needed to apply this section and determine benefits payable.

8.3.5 Facility of Payment

A payment made under another *Plan* may include an amount that should have been paid under this *Plan*. If it does, the *Plan* may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this *Plan*. The *Plan* will not have to pay that amount again. The term "payment made" includes providing benefits in the form of *Services*, in which case "payment made" means the reasonable cash value of the benefits provided in the form of *Services*.

8.3.6 Right of Recovery

If the amount of the payments made by *PHP* is more than should have paid under this COB section, *PHP* may recover the excess from one or more of the persons paid or for whom benefits were paid; or any other person or organization that may be responsible for the benefits or *Services* provided for *You* or a *Family Member*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of *Services*.

8.4 NON–DUPLICATION OF COVERAGE

8.4.1 Coordination with Medicare

In all cases, coordination of benefits with Medicare will conform to federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how *PHP* determines benefit limits under this *Plan* are affected by disability and employment status. Please contact *Your PHP* customer service team if *You* have questions.

9. PROBLEM RESOLUTION

9.1 INFORMAL PROBLEM RESOLUTION

All people who work with *Providence Health Plan* share responsibility for assuring *Participant* satisfaction. If *You* have a problem or concern about *Your* coverage, including benefits or *Services* by *Participating Providers* or payment for *Services* by *Non-Participating Providers*, please ask for *PHP's* help. *Your* customer service representatives are available to provide information and assistance. *You* may call *PHP* or meet with them at the phone number and address listed on *Your* Membership ID Card. If *You* have special needs, such as a hearing impairment, *PHP* will make efforts to accommodate *Your* requirements. Please contact *PHP* so they may help *You* with whatever special needs *You* may have.

9.2 MEMBER GRIEVANCE AND APPEAL

9.2.1 Your Grievance and Appeal Rights

If *You* disagree with *PHP's* decision about *Your* medical bills or health care services *You* have the right to three (3) levels of internal review (an initial grievance, a first level appeal and a second level appeal). *You* may request a review if you believe the *Plan* has not paid a bill correctly, will not approve care that *You* believe should be covered or is stopping care *You* believe *You* still need. *You* may also file a quality of care or general complaint with *PHP*. Please include as much information as possible including the date of the incident, name of individuals involved, and the specific circumstances. In filing a *Grievance* or appeal:

- *You* can submit written comments, documents, records and other information relating to *Your* grievance or appeal and *We* will consider that information in *PHP's* review process.
- *You* can, upon request and free of charge, have reasonable access to and copies of the documents and records held by the *Plan* that relate to *Your Grievance* or appeal.

Time Frames: To the extent possible, complaints filed by telephone will be resolved at the point of service by *a* Customer Service representative. All levels of *Grievances* and appeals (except those involving *Prior Authorizations*, as discussed below) will be acknowledged within seven (7) days of receipt by PHP and resolved within thirty (30) calendar days or sooner depending on the clinical urgency. For an initial *Grievance, PHP* may request an additional fifteen (15) days to resolve the issue if *PHP* provides *You* with a notice of delay, including a reason for the delay, before the thirty (30) day period has elapsed.

Urgent Medical Conditions*:* If *You* believe *Your* health would be seriously harmed by waiting for *PHP's* decision on *Your Prior Authorization* request, *Grievance*, or appeal, *You* may request an expedited review by calling a Customer Service

representative at 503-574-7500 or 1-800-878-4445 outside the Portland area. *PHP* will let *You* know by phone and letter if *Your* case qualifies for an expedited review. If it does, *PHP* will notify *You* of the decision within seventy-two (72) hours of receiving *Your* request.

***Grievances* and Appeals Involving *Prior Authorizations* (Non-Urgent):** If *Your Grievance* or appeal involves a *Prior Authorization* request for a non-urgent medical condition, *PHP* will notify *You* of the decision, (a) Within fifteen (15) days after *PHP* receives *Your* request for an initial grievance or first level appeal or, (b)Within thirty (30) days of receiving *Your* request for a second level appeal.

***Grievances* and Appeals Involving Concurrent Care Decisions:** If *PHP* has approved an ongoing course of treatment for *You* and determine through *PHP's* medical management procedures to reduce or terminate that course of treatment, *PHP* will provide advance notice to *You* of that decision. *You* may request reconsiderations of the decision by submitting an oral or written request at least twenty-four (24) hours before the course of treatment is scheduled to end. *PHP* will then notify *You* of the reconsideration decision within twenty-four (24) hours of receiving *Your* request.

9.2.2 Initial Grievance

You must file *Your* initial *Grievance* within 180 days of the date on *PHP's* notice of initial decision, or that initial decision will become final. Please advise PHP of any additional information that *You* want considered in the review process. If *You* are seeing a *Non-Participating Provider*, *You* should contact the provider's office and arrange for the necessary records to be forwarded to *PHP* for the review process.

9.2.3 First Level of Appeal

If *You* disagree with *PHP's* decision on *Your* initial *Grievance, You* have the right to file a first level of appeal. *Your* appeal and any additional information *You* may want reviewed must be forwarded within sixty (60) days from the date on the initial *Grievance* denial notice, or that denial will become final. The first level of appeal will be reviewed by *Providence Health Plan* staff who were not involved in the initial *Grievance.*

9.2.4 Second Level of Appeal

If *You* are not satisfied with the first level of appeal decision, *You* may request that *PHP's* Grievance Committee review *Your* appeal. The Grievance Committee is made up of *Providence Health Plan* staff and a community representative. *You* must request the Grievance Committee review within sixty (60) days of the date on the first level of appeal decision notice, or that first level appeal decision will become final. *You* may present *Your* case to the Grievance Committee in writing, in person, or by telephone conference call at *PHP's* Beaverton, Oregon location. The Grievance Committee will review the documentation presented by *You* and send a written explanation of its decision.

9.2.5 External Review

If *You* are not satisfied with the decision from the Grievance Committee and *Your* appeal involves a denial of *Services* because they are not *Medically Necessary* or because they are *Experimental/Investigational*, ***You*** **may request an external review by an Independent Review Organization (IRO).** *Your* request must be made within six months (180 days) of the receipt of the *Grievance* Committee's final internal review decision,, or that internal decision will become final. If *You* agree, *PHP* may waive the requirement that *You* exhaust the internal review process before beginning the external review process.

The IRO will notify *You* and *PHP* of its decision. The IRO is not connected in any way to *Providence Health Plan. PHP* will abide by the IRO's decision and carry out its instruction. *You* are not responsible for the cost of an independent review. **Appeals involving benefit exclusions or non-covered *Services* are not eligible for independent review.**

9.2.6 How to Submit Grievances or Appeals

You may contact *Your* Customer Service Team at 503-574-7500 or 1-800-878-4445. If *You* are hearing impaired and use a Teletype (TTY) Device, please call *PHP's* TTY line at 503-574-8702 or 1- 888-244-6642. Written *Grievances* or appeals should be sent to:

Providence Health Plan
Appeals and Grievance Department
PO Box 4447
Portland, Oregon 97208-4447

You may fax *Your Grievance* or appeal to 503-574-8757 or 1-800-396-4778, or you may hand deliver it (if mailing, use only the post office box address listed above) to the following address:

Providence Health Plan
3601 SW Murray Blvd, Suite 10
Beaverton, Oregon 97005

10. TERMINATION OF MEMBER COVERAGE

10.1 TERMINATION EVENTS

Termination of *Participant* coverage under the *Plan* will occur on the last day of the month in which a *Participant* becomes ineligible for coverage as specified in the eligibility provisions established by *PEBB.* The *PEBB* eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the *PEBB* eligibility rules for detailed information on eligibility and termination of coverage.

10.2 NON-LIABILITY AFTER TERMINATION

Upon termination of this *Plan, PEBB* shall have no further liability for *Services* received beyond the effective date of the termination.

10.3 NOTICE OF CREDITABLE COVERAGE

We will provide written certification of the *Participant's* period of *Creditable Coverage* when:

- A *Participant* ceases to be covered under the *Plan*;
- A *Participant* on COBRA coverage ceases that coverage; and
- A *Participant* requests a Notice of Creditable Coverage within 24 months of the termination of coverage.

11. CONTINUATION OF MEDICAL BENEFITS (COBRA)

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal law that applies to employers with 20 or more employees, including PEBB, continuation of *Plan* coverage may be available in certain instances, as described in this section. The term "qualified beneficiary" is used in this section to refer to a *Participant* who is qualified for enrollment in COBRA continuation coverage.

11.1 COBRA QUALIFYING EVENTS

11.1.1 PEBB Member's Continuation Coverage

A *PEBB Member* who is covered by the *Plan* may elect continuation coverage under COBRA if coverage is lost due to termination of employment (other than for gross misconduct) or a reduction in work hours.

11.1.2 Spouse's or Domestic Partner's Continuation Coverage

A spouse or domestic partner who is covered by the *Plan* has the right to elect continuation coverage under COBRA if coverage is lost for any of the following qualifying events:

- The death of the *PEBB Member*;
- The termination of the *PEBB Member's* employment (for reasons other than gross misconduct) or reduction in hours;
- The divorce or legal separation of the *PEBB Member* and the spouse;
- Termination of the domestic partnership; or
- The *PEBB Member* becomes covered under Medicare.

11.1.3 Dependent's Continuation Coverage

A dependent child who is covered under the *Plan* has the right to continuation under COBRA if coverage is lost for any of the following qualifying events:

- The death of the *PEBB Member*;
- The termination of the *PEBB Member's* employment (other than for gross misconduct) or reduction in a *PEBB Member's* hours;
- The *PEBB Member's* divorce or legal separation;
- Termination of the domestic partnership;
- The *PEBB Member* becomes covered under Medicare; or
- The child ceases to qualify as an *Eligible Family Member* under the *Plan.*

A newborn child or a child placed for adoption who is properly enrolled under the terms of the *Plan* during the COBRA continuation period will be a qualified beneficiary.

11.2 NOTICE REQUIREMENTS

A *Family Member's* coverage ends on the last day of the month in which a divorce, legal separation or termination of domestic partnership occurs or a child loses dependent status under the *Plan*. Under COBRA, *You* or *Your Family Member* has the responsibility to notify PEBB if one of these events occurs. Written notice must be given no later than 60 days after the loss of coverage has occurred, or the qualifying event, whichever is later. Oral notice is not binding until confirmed in writing. If notice is not timely given, continuation coverage will not be available.

When *PEBB* receives notification of one of the above "qualifying" events, *You* will be notified that *You* or *Your Family Member*, as applicable, have 60 days from the date coverage is lost or the date you receive the notice, whichever is later, to elect continuation coverage. If this election is not made within this 60-day period, *Your* right to elect continuation coverage under the *Plan* will be lost.

11.3 COBRA ADMINSTRATION SERVICES

PEBB has delegated the COBRA administration services to Benefit Help Solutions (BHS). *You* may contact BHS regarding COBRA administration matters at 503-765-3581 or 800-556-3137.

11.3 TYPE OF CONTINUATION COVERAGE

A qualified beneficiary will be provided the same coverage that was in effect immediately prior to the qualifying event.

11.4 COBRA ELECTION RIGHTS

A *PEBB Member* or his or her spouse or domestic partner may elect continuation coverage for all covered *Family Members*. In addition, each *Family Member* has an independent right to elect COBRA. Thus, a *Family Member* may elect continuation coverage even if the *PEBB Member* does not.

11.5 COBRA PREMIUMS

If *You* are eligible for COBRA continuation coverage, *You* do not have to show that *You* are insurable (that *You* do not have any serious health conditions). However, *You* must pay the full premium for *Your* continuation coverage, including the portion of the premium that PEBB was previously paying. After *You* elect COBRA, *You* will have 45 days from the date of election to pay the first premium. *You* must pay premium back to the point *You* would otherwise have lost coverage under the *Plan*. After that, *You* must pay the premium for each month as of the first of the month, and in all events within 30 days. If *You* fail to pay *Your* monthly premium, *You* will be notified that your coverage is being terminated.

11.6 LENGTH OF CONTINUATION COVERAGE

11.6.1 18-Month Continuation Period

When coverage ends due to an *PEBB Member's* termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period for the *PEBB Member* and all covered *Family Members* will be 18 months from the date of the qualifying event, or the date coverage is lost, whichever is later.

11.6.2 29-Month Continuation Period

If a *Participant* is disabled, continuation coverage for that qualified beneficiary and his or her covered *Family Members* may continue for up to 29 months from the date of the original qualifying event, or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

- The Social Security Administration (SSA) determines that the qualified beneficiary is disabled at any time prior to the qualifying event or during the first 60 days of COBRA continuation coverage; and
- The qualified beneficiary provides *PEBB* with a copy of the SSA determination within the initial 18-month continuation period and not later than 60 days after the SSA determination was issued.

The premium for COBRA continuation coverage may increase after the 18th month to 150% of the otherwise applicable amount.

If the SSA makes a final determination of non-disability, the qualified beneficiary must notify the COBRA Administrator within 30 days. Written notification of non-disability should be provided to:

Benefit Help Solutions
PO Box 67230
Portland, OR 97268-1230
Fax: 888-393-2943

11.6.3 36-Month Continuation Period

If a spouse, domestic partner or dependent child loses coverage because of any of the following reasons, COBRA provides for up to 36 months of continuation of coverage:

- The *PEBB Member's* death;
- The *PEBB Member's* eligibility for Medicare;
- Divorce or legal separation
- Termination of the domestic partnership; or
- A child becomes ineligible for dependent coverage.

11.6.4 Extension of Continuation Period

If second qualifying event occurs during the initial 18 or 29-month continuation period (for example, the death of the employee, divorce, or child loses status as an *Eligible Family Member* under the *Plan*), coverage for a qualified beneficiary may be extended up to 36 months. However, in no case will the continuation coverage exceed 36 months from the date of the original qualifying event.

If a spouse or dependent child has continuation coverage due to the employee's termination or reduction in hours and if the qualifying event occurred within 18 months after the employee became entitled to Medicare, the coverage period is extended to 36 months from the employee's Medicare entitlement date.

11.6.5 Extension of Coverage for a Spouse

If a surviving, divorced or legally separated spouse of a *PEBB Member* is at least 55 years old at the time of death or the dissolution or legal separation of the marriage, she or he may be eligible to continue coverage under this *Plan*. This State of Oregon provision for continuation of coverage will terminate upon the earliest of any of the following:

1. The failure to pay premiums when due, including any grace period;
2. The date that this *Plan* is terminated;
3. The date on which the surviving, divorced or legally separated spouse becomes covered under any other group health plan, including spousal coverage because of remarriage; or
4. The date on which the surviving, divorced or legally separated spouse becomes eligible for federal Medicare coverage.

The covered dependant children of the spouse also remain eligible for coverage under the *Plan* with the spouse as long as they remain otherwise eligible under the terms of the *Plan*.

11.7 THE TRADE ACT OF 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (TAA). TAA allows workers displaced by the impact of foreign trade, and individuals age 55 or older who are receiving pension benefits paid by the PBGC, to elect COBRA coverage during the 60-day period that begins on the first day of the month in which the individual first becomes eligible for TAA benefits. Eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation coverage. If *You* have questions about these new tax provisions, *You* may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY caller may call toll-free at 1-266-686-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

11.8 WHEN COBRA CONTINUATION COVERAGE ENDS

Continuation coverage will end automatically for a qualified beneficiary when any of the following events occurs:

- *PEBB* no longer provides health coverage to any *PEBB Members*;
- The premium for the continuation coverage is not paid on time;
- The qualified beneficiary later becomes covered under another health plan that has no exclusions or limitations with respect to any pre-existing conditions. If the other plan has applicable exclusions or limitations, the COBRA continuation coverage will terminate after the exclusion or limitation no longer applies;
- The qualified beneficiary later becomes entitled to Medicare;
- The earliest date that the qualified beneficiary no longer qualifies for such coverage in accordance with federal COBRA regulations; or
- The applicable maximum period of continuation coverage occurs.

11.8 CONTINUATION OF COVERAGE AFTER COBRA COVERAGE ENDS

Under federal laws and state laws, individuals who exhaust their COBRA coverage are eligible to obtain ongoing coverage, under a separate policy, known as “portability” coverage. Additional information is available:

- For Oregon residents, by contacting the Oregon Insurance Division at 503-947-7980 or at this website: http://www.cbs.state.or.us/external/ins/docs/consumer/coverage.htm#portability.
- For Washington residents, by contacting the Washington Office of the Insurance Commissioner at 800-562-6900.

12. PORTABILITY PLANS

If *Your* medical coverage under this *Plan* terminates, *Portability Plan* coverage through the Oregon Medical Insurance Pool (OMIP) may be available.

OMIP does not form part of the *Plan*, nor is it sponsored or endorsed in any way by *PEBB* or *Providence Health Plan*. Rather, OMIP is authorized under Oregon law to provide *Portability Plans* to certain Oregon residents who lose coverage under a group *Health Benefit Plan*.

12.1 ELIGIBILITY

To be eligible for Portability coverage with OMIP *You* must meet the following requirements:

1. *You* must have been covered under one or more Oregon group *Health Benefit Plans* for at least 180 days;
2. *You* must apply for Portability coverage not later than the 63rd day after termination of *Your* group coverage;
3. *You* must be an Oregon resident at the time of application; and
4. If *You* are eligible for COBRA continuation coverage, *You* must exhaust that coverage.

You are NOT eligible for Portability coverage with OMIP if:

1. *You* are eligible for federal Medicare coverage;
2. *You* remain eligible for active group coverage or COBRA continuation coverage;
3. *You* are covered, or would be covered at the time Portability coverage would otherwise begin, under another group plan, policy, contract, or agreement providing benefits for *Hospital* or medical care; or
4. *You* move out of Oregon.

12.2 EFFECTIVE DATE

Upon proper application and the payment of the applicable premiums, Portability coverage with OMIP will generally become effective on the day following the *Participant's* termination of COBRA continuation coverage under this *Plan*.

Please Note: In accordance with state mandated benefit provisions for Portability coverage, there is a 24-month *Exclusion Period* for coverage of human organ/tissue transplants. The *Exclusion Period* can be reduced or eliminated, however, by the application of *Creditable Coverage*.

For further information regarding Portability coverage with OMIP, and to receive an application for coverage, you may call the OMIP administrator, Regence Blue Cross and Blue Shield, at 1-800-848-7280.

13. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A child of a *PEBB Member* will be enrolled in the *Plan* as required by a qualified medical child support order. The procedures and rules regarding this enrollment are described in this section.

13.1 DEFINITIONS

For purposes of this section, the following definitions shall apply:

A "*Participant*" means any current or former *PEBB Member* who is covered, or who is eligible for coverage, under the *Plan* to which an Order is directed.

"Alternate Recipient" means any child of a *Participant* who is recognized under an Order as having a right to enrollment under the *Plan* with respect to such *Participant*.

An "Order" means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction (or through an administrative process established under a state law which has the effect of a court order) which:

- Provides for child support with respect to a child of a *Participant* under the *Plan* or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the *Plan*; or
- Enforces a state law relating to medical child support with respect to the *Plan*.

A "Qualified Medical Child Support Order" or "QMCSO" means an Order:

- Which creates or recognizes the existence of an Alternate Recipient's right to receive, or assigns to an Alternate Recipient the right to receive, benefits for which a *Participant* or beneficiary is eligible under the *Plan*; and
- With respect to which *PEBB* has determined satisfies the QMSCO standards set forth below.

"Procedures" means the Qualified Medical Child Support Order procedures as prescribed in this section. "Designated Representative" means a representative designated by an Alternate Recipient to receive copies of notices that are sent to the Alternate Recipient with respect to an Order.

13.2 NOTICE UPON RECEIPT OF ORDER

Upon the receipt of any Order, *PEBB* will promptly notify the *Participant* and each Alternate Recipient identified in such Order of the receipt of such Order, and will further furnish them each with a copy of these Procedures. If the Order or any accompanying correspondence identifies a Designated Representative, then copies of the acknowledgment of receipt notice and these Procedures will also then be provided to such Designated Representative.

13.3 NOTICE OF DETERMINATION

Within a reasonable period after its receipt of the Order, *PEBB* will determine whether the Order satisfies the QMCSO standards prescribed below so as to constitute a QMCSO, and shall thereupon notify the *Participant*, each Alternate Recipient, and any Designated Representative of such determination.

An Order will not be deemed to be a QMCSO unless the Order:

- Clearly specifies:
  - The name and last known mailing address (if any) of the *Participant* and of each Alternate Recipient covered by the Order (or the name and mailing address of a State or agency official acting on behalf of the Alternate Recipient);
  - Either a reasonable description of the type of coverage to be provided under the *Plan* to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
  - The period to which the Order applies.
- Does not require the *Plan* to provide any type or form of benefit, or any option, not otherwise provided under the *Plan*, except to the extent that the Order pertains to the enforcement of a state law relating to a medical child support.

If an Order contains inconsistencies or ambiguities that might pose a risk of future controversy or liability to the *Plan*, the Order will not be considered to be a QMCSO.

13.4 ENROLLMENT OF ALTERNATE RECIPIENT

An Alternate Recipient with respect to an Order determined to be a QMCSO who properly submits the applicable enrollment forms to *PEBB* will become covered under the *Plan* to which such Order applies as soon as practicable after the applicable enrollment forms are received. An Alternate Recipient will be eligible to become covered under the *Plan* as of a particular date without regard to any open enrollment period restrictions otherwise applicable under the *Plan*.

13.5 COST OF COVERAGE

An Alternate Recipient will be treated as having been voluntary enrolled in the *Plan* by the *Participant* as a dependent of such *Participant,* including in regard to the payment by the *Participant* for dependent coverage under the *Plan*. The amount of any required contributions to be made by the *Participant* for coverage under the *Plan* will be determined on the basis of the Alternate Recipient being treated as the *Participant's* covered dependent. Any additional required contribution attributable to the coverage of the Alternate Recipient will not be separately charged. Rather, the full amount of the required contribution shall be paid by the *Participant* in accordance with the payroll deduction or other procedures of the *Plan* as pertaining to the *Participant*.

13.6 REIMBURSEMENT OF PLAN EXPENSES

Unless the terms of the Order provide otherwise, any payments to be from the *Plan* as reimbursement for group health expenses paid either by the Alternate Recipient, or by the custodial parent or legal guardian of the Alternate Recipient, will not be paid to the *Participant*. Rather, such reimbursement will be paid either to the Alternate Recipient, or to the custodial parent or legal guardian of such Alternate Recipient. However, if the name and address of a State or agency official has been substituted in the Order for that of the Alternate Recipient, then the reimbursement will be paid to such named official.

13.7 STATUS OF ALTERNATE RECIPIENT

An Alternate Recipient under a QMCSO generally will be considered a beneficiary of the *Participant* under the *Plan* to which the Order pertains.

13.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE

If *PEBB* receives an appropriately completed National Medical Support Notice (NMSN) issued pursuant to the Child Support Performance and Incentive Act of 1998 in regard to a Participant who is a non-custodial parent of a child, and if the NMSN is determined by *PEBB* to satisfy the QMCSO standards prescribed above, then the NMSN shall be deemed to be a QMCSO respect to such child.

PEBB, upon determining that the NMSN is a QMCSO, shall within 40 business days after the date of the NMSN notify the State agency issuing the NMSN of the following:

- Whether coverage of the child at issue is available under the terms of the *Plan*, and if so, as to whether such child is covered under the *Plan*; and
- Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the State or agency official acting on behalf of the child) to effectuate the coverage under the *Plan*.

PEBB shall within such time period also provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

Nothing in this section shall be construed as requiring the *Plan*, upon receipt of a NMSN, to provide benefits under the *Plan* (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the *Plan* as in effect immediately before receipt of such NMSN.

14. GENERAL PROVISIONS

14.1 DUPLICATING PROVISIONS

If any charge is described as covered under two or more benefit provisions, the *Plan* will pay only under the provision allowing the greater benefit. This may require a recalculation based upon both the amounts already paid and the amounts due to be paid. The *Plan* has NO liability for benefits other than those this *Plan* provides.

14.2 FAILURE TO PROVIDE INFORMATION

You warrant that all information contained in applications, questionnaires, forms, or statements submitted to *PEBB* and to *PHP* to be true, correct, and complete. If *You* willfully fail to provide information required to be provided under this *Plan* or knowingly provide incorrect or incomplete information, then *Your* rights and those of *Your Family Members* may be terminated as described in the Disenrollment section.

14.3 MEMBER RESPONSIBILITY

It is *Your* responsibility to read and to understand the terms of this *Plan*. Neither *PEBB* nor *Providence Health Plan* will have any liability whatsoever for *Your* misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this *Plan*. If *You* have any questions or are unclear about any provision concerning this *Plan*, please contact *PHP*. They will assist *You* in understanding and complying with the terms of the *Plan*.

14.4 MEMBERSHIP ID CARD

The Membership ID Card is issued by *Providence Health Plan* for *Participant* identification purposes only. It does not confer any right to *Services* or other benefits under this *Plan*.

14.5 NON-TRANSFERABILITY OF BENEFITS

No person other than a *Participant* is entitled to receive benefits under this *Plan*. Such right to benefits is nontransferable.

14.6 NONWAIVER

No delay or failure when exercising or enforcing any right under this *Plan* shall constitute a waiver or relinquishment of that right and no waiver or any default under this *Plan* shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this *Plan* shall be deemed to have been made unless and until such waiver has been reduced to writing and signed by the party waiving the provision.

14.7 NO RECOURSE FOR ACTS OF PROVIDERS

The *Hospitals, Skilled Nursing Facilities*, physicians and other persons or organizations providing *Services* to *You* do so as independent contractors. Neither *PEBB* nor *Providence Health Plan* is liable for any claim or demand due to damages arising out of or in any manner connected with any injuries suffered by *You* while receiving such *Services*.

14.8 NOTICE

Any notice required of *PEBB* or *Providence Health Plan* under this *Plan* shall be deemed to be sufficient if mailed to the *Participant* at the address appearing on the records of *Providence Health Plan*. Any notice required of *You* shall be deemed sufficient if mailed to the principal office of *Providence Health Plan* at P.O. Box 4447 Portland, OR 97208.

14.9 NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIM

Plan payments for most *Services* are made directly to the providers of *Services*. Except as otherwise specifically provided in this *Plan*, if *You* are billed directly and pay for benefits which are covered by this *Plan*, reimbursement from the *Plan* will be made only upon *Your* written notice to *PHP* of the payment. Payment will be made to the *Participant*, subject to written notice of claim, or, if deceased, to the *Participant's* estate, unless payment to other parties is authorized in writing by you. See section 8.3.8 regarding timely submission of claims.

14.10 PHYSICAL EXAMINATION AND AUTOPSY

When reasonably required for purposes of claim determination, *PEBB* shall have the right to make arrangements for the following examinations, at *Plan* expense, and to suspend the related claim determination until *Providence Health Plan* has received and evaluated the results of the examination:

- A physical examination of a *Participant*; or
- An autopsy of a deceased *Participant*, if not forbidden by law.

14.11 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS

All *Participants*, by acceptance of the benefits of this *Plan*, shall be deemed to have consented to the examination of medical records for purposes of utilization review, quality assurance and peer review by *Providence Health Plan* or their designee.

All *Participants*, for purposes other than utilization review, quality assurance and peer review, may be required to authorize any provider to give and discuss with *PHP* any information relating to any condition for which benefits are claimed under this *Plan*. *PHP* may transfer this information between providers or other organizations who are treating *You* or performing a service on behalf of *PHP*. If *You* do not consent to the release of records or to discussions with providers, *PHP* will be unable to determine the proper payment of any benefits and will deny the claims accordingly. Consent to the release of records and discussion with providers is a condition of payment of any benefits. Neither the consent to, nor the actual examination of the records or discussion with providers will constitute a guarantee of payment.

14.12 SEVERABILITY

Invalidation of any term or provision herein by judgment or court order shall not affect any other provisions, which shall remain in full force and effect.

14.13 SUGGESTIONS

You are encouraged to make suggestions to *PHP*. Suggestions may be oral or written and should be directed to the customer service team at the *Providence Health Plan* administrative office.

14.14 RIGHT OF RECOVERY

PHP, on behalf of the *Plan*, has the right, upon demand, to recover payments in excess of the maximum benefits specified in this *Plan* or payments obtained through fraud, error, or duplicate coverage. If reimbursement is not made to the *Plan*, *PHP* is authorized by *PEBB* to deduct the overpayment from future benefit payments under this *Plan*.

14.15 WORKERS' COMPENSATION INSURANCE

This *Plan* is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation or similar laws.

14.16 NO GUARANTEE OF EMPLOYMENT

Neither the maintenance of the *Plan* nor any part thereof shall be construed as giving any *PEBB Member* covered hereunder or other *PEBB Members* any right to remain in the employ of the State of Oregon. No employee or official of *PEBB* in any way guarantees to any *Participant* or beneficiary the payment of any benefit or amount which may become due in accordance with the terms of the *Plan*.

14.17 REQUIRED INFORMATION TO BE FURNISHED

Each *Participant* must furnish *PHP* such information as *is* considered necessary or desirable for purposes of administering the *Plan*, and the provisions of the *Plan* respecting any payments hereunder are conditional upon the prompt submission by the *Participants* of such true, full and complete information as *PHP* may request.

14.18 PAYMENT OF BENEFITS TO PERSONS UNDER LEGAL DISABILITY

Whenever any person entitled to payments under the *Plan* is determined to be a minor or under other legal disability or otherwise incapacitated in any way so as to be unable to manage such person's financial affairs, or otherwise incapable of giving a valid receipt and discharge for any payment, the following provision shall apply. *PHP*, in its discretion, may direct that all or any portion of such payments be made (i) to such person, (ii) to such person's legal guardian or conservator, or (iii) to such person's spouse or to any other person, in any manner which *PHP* considers advisable, to be expended for the person's benefit. *PHP's* decision will, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred shall operate as a complete discharge of the obligations under the *Plan* in respect thereof by *PEBB* and *PHP*.

14.19 STATE MEDICAID BENEFITS RIGHTS

Notwithstanding any provision of the *Plan* to the contrary:

- Payment for benefits with respect to a *Participant* under the *Plan* shall be made in accordance with any assignment of rights made by or on behalf of such *Participant*, or a *Family Member*, as required by a State Medicaid Plan;
- The fact that an individual is eligible for or is provided medical assistance under a State Medicaid Plan shall not be taken into account in regard to the individual's enrollment as a *Participant* or beneficiary in the *Plan*, or in determining or making any payments for benefits of the individual as a *Participant* or *Family Member* in the *Plan*; and
- Payment for benefits under the *Plan* shall be made to a state in accordance with any state law which provides that the state has acquired the rights with respect to a *Participant* for items or services constituting medical assistance under a State Medicaid Plan.

For purposes of the above, a "State Medicaid Plan" means a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act.

14.20 VETERAN'S RIGHTS

The *Plan* will provide benefits to *Participants* entering into or returning from service in the armed forces as may be required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). In general, USERRA provides that:

- A *Participant* who takes unpaid military leave, or who separates from employment to perform services in the armed forces or another uniformed service, can elect continued coverage under the *Plan* (including coverage for the *Eligible Family Dependents*) on a self-pay basis. The applicable *Contribution* for such coverage, and the *Contribution* payment procedures, shall be as generally prescribed for COBRA continuation coverage in section 11. Effective for elections made on or after December 10, 2004, the period for such continuation coverage shall extend until the earlier of:

(a) The end of the 24-month period beginning on the date on which the *Participant's* absence for the purpose of performing military service begins; or

(b) The date the *Participant* fails to timely return to employment or reapply for a position covered by *PEBB* upon the completion of such military service.

14.21 CONTROLLING STATE LAW

The laws of the State of Oregon shall apply and shall be the controlling state law in all matters relating to the *Plan*.

14.22 LIMITATIONS ON PROVISIONS

The provisions of the *Plan* and any benefits provided by the *Plan* shall be limited as described herein. Any benefit payable under any other employee benefits plan maintained by *PEBB* shall be paid solely in accordance with the terms and provisions of such plan, and nothing in this *Plan* shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

14.23 GENDER AND NUMBER

Masculine gender shall include the feminine and neuter, the singular shall include the plural, and the plural shall include the singular, unless the context clearly indicates otherwise.

14.24 HEADINGS

All article and section headings in the *Plan* are intended merely for convenience and shall in no way be deemed to modify or supplement the actual terms and provisions set forth there under.

14.25 CONFLICTS OF PROVISIONS

In the event that one or more provisions of this document conflict with one or more provisions of any other plan document, the provisions of this document, as from time to time amended, shall control.

14.26 LEGAL ACTION

No civil action may be brought under state or federal law to recover *Plan* benefits until receipt of a final decision under the Member Grievance and Appeal process specified in section 9.2 of this *Member Handbook*.

14.27 PROTECTED HEALTH INFORMATION

Disclosure: In accordance with the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), *PHP* may disclose de-identified summary health information to *PEBB* for purposes of modifying, amending or terminating this *Plan*. In addition, *PHP* may disclose protected health information (PHI) to *PEBB* in accordance with the following provisions of this *Plan* as established by *PEBB*:

(a) *PEBB* may use and disclose the PHI it receives only for the following purposes:

1. Administration of the Plan; and
2. Any use or disclosure as required by law.

(b) *PEBB* shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to *PEBB* with respect to such information.

(c) *PEBB* shall not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of *PEBB*.

(d) *PEBB* shall report to *PHP* any use or disclosure of PHI that is inconsistent with the provisions of this section of which the *Employer* becomes aware.

(e) *PEBB* shall make PHI available to *Participants* in accordance with the privacy regulations of HIPAA.

(f) *PEBB* shall allow *Participants* to amend their PHI in accordance with the privacy regulations of HIPAA.

(g) *PEBB* shall provide *Participants* with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.

(h) *PEBB* shall make its internal practices, books and records relating to the use and disclosure of PHI received from *PHP* available to the Secretary of the Department of Health and Human Services in accordance with the privacy regulations of HIPAA.

(i) *PEBB* shall, if feasible, return or destroy all PHI received from *PHP* and retain no copies of such information when no longer needed for the purpose for which such information was received except that, if such return or destruction is not feasible, PEBB shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(j) *PEBB* shall provide for adequate separation between *PEBB* and *PHP* with regard to the use and disclosure of PHI. For that purpose, access to PHI shall be limited to the following employees or classes of employees of *PEBB* or designated individuals:

1. Benefit Manager;
2. Director of Operations;
3. *PEBB's* Designated Consultants; and
4. Internal Auditors, including representatives of the Oregon Secretary of State or Department of Justice, when performing Health Plan Audits.

Further, *PEBB* shall restrict the access to and use of PHI by the employees designated above to the administrative functions that those employees perform for *PEBB* with regard to this *Plan*. In addition, *PEBB* shall establish an effective mechanism for resolving any issues of non-compliance by the employees designated above with regard to their use of PHI.

Security: In accordance with the security standards of HIPAA, *PEBB* shall:

(a) Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the *Plan*;

(b) Ensure that the separation of access to PHI that is specified in paragraph (j) above is supported by appropriate security measures;

(c) Ensure that any agent or subcontractor to whom *PEBB* provides PHI agrees to implement appropriate security measures to protect such information; and

(d) Report to the *Plan* any security incident regarding PHI of which *PEBB* becomes aware.

15. PRESCRIPTION DRUG BENEFITS

The prescription drug benefits that are available under this *Plan* are described in this section and in the Prescription Drug *Summary of Benefits*. All *Covered Services* are subject to the specific conditions, duration limitations and all applicable maximums that are specified in this *Member Handbook*.

This *Plan* will provide benefits for prescription drugs which are *Medically Necessary* for the treatment of a covered illness or injury and which are dispensed by a participating pharmacy pursuant to a prescription ordered by a *Qualified Practitioner* for use on an outpatient basis. Participating pharmacies are those pharmacies that maintain all applicable certifications and licenses necessary under state and federal law of the United States and have an agreement with *PHP* to provide prescription drug benefits. *PHP* has approximately 20,000 participating pharmacies available for *Participant* use nationwide.

15.1 USING YOUR PRESCRIPTION DRUG BENEFITS

- *Participants* must access prescription drug *Services* through *Participating Providers* and participating pharmacies. *You* may obtain a list of *PHP's* participating pharmacies from *their* website at www.providence.org/healthplans or by contacting *PHP's* Customer Service Team at the telephone number listed on *Your* Membership Identification Card (ID Card).
- All *Covered Services* are subject to the *Copayments* or *Coinsurance* amounts and benefit maximums shown in the Prescription Drug *Summary of Benefits*. *Copayments* or *Coinsurance* amounts for prescription drug *Covered Services* do not apply to the *Participant's* medical annual *Out-of-Pocket Maximum* and are due at the time of purchase. Participating pharmacies may not charge *You* more than *Your Copayment* or *Coinsurance*. Please contact *Your* Customer Service Team if *You* are asked to pay more or if *You* or the pharmacy have questions about *Your* prescription drug benefits or need assistance processing *Your* prescription.
- Some drugs require *Prior Authorization* for *Medical Necessity*, length of therapy, step therapy, number of doses or dispensing limits. The current list of drugs that require *Prior Authorization* is available from *Your* Customer Service Team and from *the PHP* website at: http://www.providence.org/healthplans/members/pharmacy/default.aspx
- *You* may purchase up to a 90-day supply of each maintenance drug at one time using a participating mail service pharmacy, as described under the Participating Mail Order Pharmacy section or a Preferred Retail Pharmacy. Not all prescription drugs are available through the mail order pharmacies.
- Diabetes supplies and inhalation extender devices may be obtained at a participating pharmacy. However, such items are considered medical supplies and devices and are covered under the benefit provisions of section 5.7.9 rather than the prescription drug provisions of this section 15.
- *You* must present *Your* ID Card to the participating pharmacy at the time *You* request *Services*. *Your* use of the ID Card for prescription drugs helps streamline pharmacy costs and eliminates extra work for *You*, the pharmacist and *PHP*. If *You* have misplaced *Your* ID Card or don't have *Your* ID Card with *You* when *You* need to purchase prescription drugs, please ask *Your* pharmacist to call *PHP*.

15.2 USE OF NON-PARTICIPATING PHARMACIES

On rare occasions, such as urgent or emergency situations, *You* may need to use a non-participating pharmacy. If this happens, *You* will need to pay full price for *Your* prescription at the time of purchase. *You* may be reimbursed by the *Plan* upon submission of a Prescription Drug Reimbursement form, which can be obtained from *the PHP* website or by contacting *Your* Customer Service Team. *You* must include any itemized pharmacy receipts along with this form. *You* will also need to provide an explanation as to why *You* used a non-participating pharmacy. Once received, *Your* claim will be reviewed (submission of a claim does not guarantee payment). If *Your* claim is approved, *PHP* will reimburse *You* the cost of *Your* prescription up to *the* participating pharmacy contracted rates, subject to the terms of this *Plan* and the Prescription Drug *Summary of Benefits*, less *Your* applicable *Copayment* or *Coinsurance*. *You* are responsible for any amounts above *PHP's* contracted rates.

15.3 PRESCRIPTION DRUG DEFINITION

The following are considered "prescription drugs":

1. Any medicinal substance which bears the legend, "Caution: federal law prohibits dispensing without a prescription";
2. Any medicinal substance which may be dispensed by prescription only, according to state law;
3. Insulin. Once *You* have received insulin for the first time with a prescription, *You* will not need another prescription to obtain insulin thereafter;
4. Any medicinal substance of which a least one ingredient is a federal or state legend drug in a therapeutic amount; and

15.4 PRESCRIPTION DRUG FORMULARY

A prescription drug formulary means a list of drugs, current clinical drug information, therapeutic approach to disease and comparative cost information to be used as a reference by prescribing physicians.

Providence Health Plan maintains a closely managed, open formulary. Formulary status is given to drugs that meet evidence-based assessment of therapeutic effectiveness, safety, pharmacoeconomic value and offer an important advantage to existing formulary alternatives.

Newly approved FDA drugs may be excluded from *PHP's* formulary for up to 12 months after FDA approval, pending review for safety and medical necessity by *PHP's* Pharmacy & Therapeutics Committee. In the case of an urgent situation, *PHP* will authorize the use of a newly-approved FDA drug during *their* review period so a *Participant* does not go without *Medically Necessary* treatment.

PHP's formulary is updated regularly throughout the year and *Qualified Practitioners* are encouraged to submit suggestions for additions to *PHP*. *You* may obtain a copy of the formulary from the *PHP* website or by contacting *Your* Customer Service Team.

***Your* Costs for Non-Formulary (Non-Preferred Brand Name) Drugs:**

- If *You* request, or *Your* physician prescribes, a non-preferred (non-formulary) brand name drug when a generic equivalent is available, *You* will be responsible for the difference in cost between the non-preferred brand name drug and the generic drug, in addition to the non-preferred brand *Copayment*. The total cost, however, will never exceed the cost of the drug.

15.5 GENERIC AND BRAND NAME PRESCRIPTION DRUGS

Both generic and brand names drugs are covered as specified in this section. In general, generic drugs are subject to lower *Copayments* or *Coinsurance* amounts than brand name drugs. Please refer to the Prescription Drug *Summary of Benefits* for *Your Copayment* or *Coinsurance* information.

Generic medication means a prescription medication that is:

- An **equivalent medication** to the **brand name medication**;
- Is marketed as a therapeutically equivalent and interchangeable product; and
- Is listed in widely accepted references as a **generic medication** and is specified as a **generic medication** in this *Plan*.

Equivalent medication means the US Food and Drug Administration (FDA) ensures that the **generic medication** must:

- Have the same active ingredients;
- Meet the same manufacturing and testing standards; and
- Be absorbed into the bloodstream at the same rate and same total amount as the **brand name medication**.

These requirements ensure that the generic medication has the same effectiveness as the brand name medication. If listings in widely accepted references are conflicting or indefinite about whether a prescription medication is a generic or brand medication, *PHP* will determine whether the prescription medication is a generic or brand name medication.

Brand name medication (**single source brand**) means a prescription medication that has a current patent and is marketed and sold by limited sources or is listed in widely accepted references as a brand name medication based on manufacturer and price.

Multi-source brand name medication means a brand name medication for which a **generic medication** may be substituted under the laws and regulations of the state in which the pharmacy dispensing the prescription is located.

Exception Process:

An exception process is available if the prescribing provider believes that it is medically necessary for *You* to use a non-preferred (non-formulary) brand name drug instead of a preferred (formulary) brand name or generic drug. A request for medical exception that explains why the drug substitution is medically appropriate may be submitted by your provider to PHP. If the request is approved, the benefits for **preferred** (formulary) brand name drugs will apply. If the request is denied, the appeal rights described in section 9 will apply.

15.6 PRESCRIPTION QUANTITY

Prescription dispensing limits, including refills, are as follows: 1) topicals, up to 60 grams; 2) liquids, up to eight ounces; 3) tablets or capsules, up to 100 dosage units; and 4) multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30 consecutive day supply, whichever is less. Other dispensing limits may apply to certain medications requiring limited use, as determined by *PHP's* medical policy. *Prior Authorization* is required for amounts exceeding any applicable medication dispensing limits.

15.7 PARTICIPATING MAIL ORDER PHARMACY

Prescribed maintenance drugs (pharmaceutical products that for the majority of patients are prescribed in a constant, on-going manner) purchased from a participating mail order pharmacy will be covered subject to the following specific provisions:

1. Qualified drugs under this program will be determined by *PHP*. Not all drugs are available through mail order pharmacy.
2. *Copayment(s)* will be applied to the quantity stated in the Prescription Drug *Summary of Benefits*.

Payment is required prior to processing *Your* order. If there is a change in *PHP's* participating mail service pharmacies, *You* will be notified of the change at least 30 days in advance.

To purchase prescriptions by mail, *Your* physician or provider can call in the prescription or *You* can mail *Your* prescription along with a notation of *Your PHP* ID number to a participating mail order pharmacy. Participating mail order information is available on the *PHP* website at www.providence.org/health_plans.

15.8 PRESCRIPTION DRUG LIMITATIONS

Prescription drug limitations are as follows:

1. Imitrex (migraine headache treatment) is covered for two (2) boxes (four (4) injections) per month. In addition, oral and nasal migraine medications are limited to two (2) unit-of-use packages per month. *Prior Authorization* is required for additional amounts;
2. DDAVP prescribed for the treatment of enuresis is limited to a two-month supply per lifetime per *Member*;
3. Medications, drugs or hormones prescribed to stimulate growth are not covered except when there is a laboratory confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults; and
4. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount and must meet *PHP's* medical necessity criteria.

15.9 PRESCRIPTION DRUG EXCLUSIONS

In addition to the limitations and exclusions set forth in this *Member Handbook*, no *Services* or materials will be provided for:

1. Any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K;
2. Drugs or medicines delivered, injected, or **administered to *You* by a physician or other provider**;
3. **Amphetamines** and amphetamine derivatives except when used in the treatment of narcolepsy or hyperactivity in children and adults;
4. Drugs used in the treatment of the **common cold**;
5. Drugs or medications prescribed that do not relate to the treatment of a **covered illness or injury**;
6. **Devices, appliances, supplies and *Durable Medical Equipment*** of any type, even though such devices may require a prescription order. (Some of these items may be covered under *Your* medical benefits. Please refer to the Medical *Summary of Benefits*.);
7. **Experimental** or **investigational** drugs or drugs used by a *Participant* in a research study or in another similar investigational environment;
8. **Fluoride**, for *Participants* over the age of 10 years old;
9. Drugs that are not provided in accordance with the *Plan's* **formulary** management program, unless approved in the exception process;
10. Drugs used in the treatment of **fungal** nail conditions;
11. Drugs to stimulate **Hair Growth,** including, but not limited to **Rogaine** (topical minoxidil) or other similar drug preparations;
12. **Injectable medications** unless they are: intended for self-administration; labeled by the FDA for self-administration; purchased through Providence Specialty Pharmacy, a division of Providence Home Services; and shown on *PHP's* list of "Self-Administered Injectable Drugs." This list may be modified at any time according to the latest medical information available and as determined by *PHP's* medical policy. *You* may obtain a copy of this list from *the PHP* website or by contacting *Your* Customer Service Team.
13. **Intrauterine devices** (IUDs), diaphragms and implantable contraceptives. (Some of these items may be covered under *Your* medical benefits. Please refer to the Medical *Summary of Benefits*.);
14. Drugs or medications prescribed that are not ***Medically Necessary*** or are not provided according to the *Plan's* medical policy or *Prior Authorization* requirements;

15. **Methadone** is covered for pain management but is excluded for the treatment of chemical dependency. Methadone to treat chemical dependency is covered under the medical chemical dependency benefit when the treatment is part of an approved medically supervised treatment program and is subject to any applicable benefit limits;
16. Drugs prescribed by **naturopathic** physicians (N.D.);
17. **Over-the-Counter (OTC) drugs, medications** or **vitamins**, that may be purchased without a provider's written prescription and prescription drugs for which there are OTC therapeutic equivalents;
18. Drugs dispensed from **pharmacies outside the United States**, except when prescribed for *Urgent/Immediate Care* and *Emergency Medical Conditions*;
19. Drugs which, by law, do not require a **prescription**, except insulin;
20. **Replacement of lost** or stolen medication;
21. Drugs or medicines used to treat **sexual dysfunctions or disorders**, in either men or women, such as **Viagra** or drugs required for, or as a result of, sexual transformation;
22. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA approved medication in **therapeutic amount**; and
23. Drugs used for **weight loss** or for **cosmetic** purposes.
24. Drugs used in the treatment of shift-work sleep disorders, drug induced fatigue, general fatigue and idiopathic hypersomnia.
25. Drugs place on prescription-only status by federal or state mandate outside of required FDA-status assignment (i.e., OTC drugs such as Sudafed).

15.10 PRESCRIPTION DRUG DISCLAIMER

The *Plan* and *Providence Health Plan* are not liable for any claim, injury, demand, or judgment based on tort or other grounds (including, but not limited to, warranty or merchantability) arising out of or in any connection with the sale, compounding, dispensing, manufacturing, or use of any prescription drug covered under this *Plan.*

16. DEFINITIONS

The following are definitions of important terms used in this *Plan* and appear throughout as italic text.

Annual Group Enrollment Period

Annual Group Enrollment Period means the period determined by the *PEBB* Board during which *PEBB Members* and their *Eligible Family Dependents* may enroll in this *Plan* for the upcoming *Plan Year*, subject to the terms and provisions as found in the Eligibility and Enrollment section of this *Member Handbook.*

Chemical Dependency

Chemical Dependency means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems. *Chemical Dependency* does not mean an addiction to, or dependency on tobacco, tobacco products, or foods.

Coinsurance

Coinsurance means the dollar amount that *You* are responsible to pay to a health care provider for a *Covered Service* that is a percentage of the allowable fee under this *Plan* for the *Covered Service*, as shown in the *Summary of Benefits*.

Confinement

Confinement means being a resident patient in a *Hospital*, *Skilled Nursing Facility* or *Qualified Treatment Facility* for at least 15 consecutive hours. Successive *Confinements* are considered to be one *Confinement* if:

1. Due to the same injury or illness; and
2. Separated by fewer than 30 consecutive days when *You* are not confined.

Contribution

Contribution means the dollar amount that a *Participant* may be required to pay as a condition to coverage under the *Plan* toward the monthly premium cost of the *Plan* established by *PEBB.*

Copayment

Copayment means the dollar amount that *You* are responsible for paying to a health care provider when *You* receive certain *Covered Services*, as shown in the *Summary of Benefits*.

Cosmetic Services

Cosmetic Services means *Services* or surgery performed to reshape normal structures of the body in order to improve *Your* appearance or self-esteem.

Covered Service

Covered Service means a *Service* that is:

1. Listed as a benefit in the *Summary of Benefits* and in the *Covered Services* section of this *Member Handbook*;
2. *Medically Necessary*;
3. Not listed as an Exclusion or Limitation in the *Summary of Benefits* or in the relevant sections of this *Member Handbook*; and
4. Provided *to You* while *You* are a *Participant* and eligible for the *Service* under this *Plan*.

Creditable Coverage

Creditable Coverage means prior health care coverage as defined in 42 U.S.C. § 300gg and includes any coverage remaining in force at the time a *Participant* obtains new coverage. *Creditable Coverage* includes any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage, Medicare, Medicaid, CHAMPUS, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or a domestic or foreign public health plan as defined in 42 U.S.C. § 300gg.

Custodial Care

Custodial Care means *Services* that:

1. Do not require the technical skills of a licensed nurse at all times;
2. Include, but are not limited to, assistance with dressing, bathing, eating, ambulation, taking medication and incontinence care; and
3. Are not likely to improve *Your* medical condition.

Such *Services* will still be considered *Custodial Care* even if:

1. *You* are under the care of a physician;
2. The *Services* are prescribed by a *Participating Provider*;
3. The *Services* function to support or maintain *Your* condition; or
4. The *Services* are being provided by a registered nurse or licensed practical nurse.

Dependent

Dependent means a person who is supported by the *Participant* or the *Participant's* spouse or domestic partner. See also *Eligible Family Dependent*.

Durable Medical Equipment (DME)

Durable Medical Equipment means equipment that must:

1. Be able to withstand repeated use;
2. Be primarily and customarily used to serve a medical purpose; and
3. Not be generally useful to a person except for the treatment of an injury or illness.

Effective Date of Coverage

Effective Date of Coverage means the date upon which coverage under this *Plan* commences for a *PEBB Member*, which shall be: The first day of the month after which a *PEBB Member* is properly enrolled.

Eligible Family Dependent – See section 4.2

Eligibility Waiting Period

Eligibility Waiting Period means the period of employment, as specified in the eligibility provisions established by *PEBB*, that a *PEBB Member* must complete before coverage will begin under this *Plan*. If a *PEBB Member* enrolls on a special enrollment date, any period before such special enrollment is not an *Eligibility Waiting Period.*

Emergency Medical Condition

Emergency Medical Condition means a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus, in the case of a pregnant woman, in serious jeopardy.

Emergency Medical Screening Exams

Emergency Medical Screening Exams include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an *Emergency Medical Condition*.

Emergency Services

Emergency Services means those health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for the stabilization of the patient.

E-visit

E-visit (electronic provider communications) means a consultation through e-mail with a *Participating Provider* that is, in the judgment of the *Participating Provider*, *Medically Necessary* and appropriate and involves a significant amount of the *Participating Provider's* time. An *E-visit* must relate to the treatment of a covered illness or injury.

Exclusion Period

Exclusion Period means a period of time during which specified treatments or *Service*s are excluded from coverage under this *Plan*, unless such exclusion is modified or eliminated by the application of *Creditable Coverage*.

Experimental/Investigational

Experimental/Investigational means those *Services* that are determined by *Providence Health Plan* not to be *Medically Necessary* or accepted medical practice in the *Service Area*, including *Services* performed for research purposes. In determining whether *Services* are *Experimental/Investigational*, *Providence Health Plan*, as the *Plan's* claims administrator, will consider whether the *Services* are in general use in the medical community in the U.S.; whether the *Services* are under continued scientific testing and research; whether the *Services* show a demonstrable benefit for a particular illness or disease; whether they are proven to be safe and efficacious; and

whether they are approved for use by appropriate governmental agencies. *Providence Health Plan* determines on a case-by-case basis whether the requested *Services* will result in greater benefits than other generally available *Services*, and will not approve such a request if the *Service* poses a significant risk to the health and safety of the *Member*. *Providence Health Plan* will retain documentation of the criteria used to define a *Service* deemed to be *Experimental/Investigational* and will make this available for review upon request.

Family Member

Family Member means an *Eligible Family Dependent* who is properly enrolled in the *Plan*, entitled to *Services* and covered under this *Plan*.

Grievance

Grievance means a written complaint that may be submitted by or on behalf of a *Participant* regarding the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; claims payment; handling of reimbursement for health care services; or matters pertaining to the contractual relationship between a *Participant* and the *Plan*.

Health Benefit Plan

Health Benefit Plan means any hospital or medical expense policy or certificate issued by a health care service contractor or health maintenance organization and any plan provided by a multiple employer welfare arrangement or other benefit arrangement defined in *ERISA*.

Home Health Provider

A *Home Health Provider* is a public or private agency that specializes in providing skilled nursing *Services* and other therapeutic *Services* in the home and which has been licensed by the proper authority as a Home Health Agency, or is Medicare approved as a Home Health Agency.

Hospital

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician or surgeon in regular attendance;
3. Provides continuous 24-hour-a-day nursing *Services*;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical *Services* with an institution having a valid license to provide such surgical *Services*.

Hospital does NOT include an institution that is principally a rest home, nursing home, convalescent home or home for the aged. *Hospital* does NOT include a place principally for the treatment of alcohol or *Chemical Dependency* or *Mental Health* disorders.

In Plan

The level of benefits specified in the Summary of Benefits or covered services provided by a provider participating in the Providence Choice Plan network.

Lifetime Maximum Benefit

Lifetime Maximum Benefit means the $2 million limit of total benefits payable by the *Plan* during the lifetime of a *Participant while they are enrolled in a medical plan sponsored by PEBBs.*

Medical Home Provider

Medical Home Provider means a provider within the *Providence Choice Network* who has agreed to provide or coordinate the provision of medical care to *Participants* and is listed in the *Medical Home Provider* section of the *Providence Choice Network* Provider Directory.

Medically Necessary

Medically Necessary means *Services* that are in the reasonable opinion of *Providence Health Plan*, consistent with the written criteria regarding medically indicated *Services* that are maintained by the *Providence Health Plan*. The criteria are based on the following principles:

1. The *Service* is medically indicated according to the following factors:
    - The *Service* is necessary to diagnose or to meet the reasonable health needs of the *Member*;
    - The expected health benefits from the *Service* are clinically significant and exceed the expected health risks by a significant margin;
    - The *Service* is of demonstrable value and that value is superior to other *Services* and to the provision of no *Services*; and
    - Expected health benefits can include:
        a. Increased life expectancy;
        b. Improved functional capacity;
        c. Prevention of complications; or
        d. Relief of pain.
2. The *Qualified Practitioner* recommends the *Service*.
3. The *Service* is rendered in the most cost-efficient manner and type of setting consistent with nationally recognized standards of care, with consideration for potential benefits and harms to the patient.
4. The *Service* is consistent in type, frequency and duration with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the *Plan*.

In the case of a life-threatening illness, a *Service* that would not meet the criteria above may be considered *Medically Necessary* for purposes of reimbursement, if:

- It is considered to be safe within promising efficacy, as demonstrated by accepted clinical evidence reported by generally-recognized medical professionals or publications; and
- The treatment is provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health for a life-threatening condition.

For the purpose of this exception, the term “life-threatening” means more likely than not to cause death within one year of the date of the request for diagnosis or treatment.

Member Handbook

Member Handbook means this document which summarizes the provisions of this *Plan*.

Mental Health

Mental Health means *Services* related to all disorders listed in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" except for:

1. Diagnostic codes relating to Mental Retardation - 317 (Mild), 318.0 (Moderate), 318.1 (Severe), 318.2 (Profound) and 319 (Severity Unspecified);
2. Diagnostic codes relating to Learning Disorders - 315.00 (Reading), 315.1 (Mathematics), 315.2 (Written Expression) and 315.9 (Not Otherwise Specified);\
3. Diagnostic codes relating to Paraphilias - 302.2 (Pedophilia), 302.4 (Exhibitionism), 302.81(Fetishism), 302.82 (Voyeurism), 302.83 (Sexual Masochism), 302.84 (Sexual Sadism), 302.89 (Frotteurism) and 302.9 (Not Otherwise Specified);
4. Diagnostic codes relating to Gender Identity Disorders in Adults - 302.6 (Not Otherwise Specified), 302.85 (Gender Identity) and 302.9 (Sexual Disorder Not Otherwise Specified). This exception does not extend to children and adolescents 18 years of age or younger; and
5. Diagnostic "V"codes - V15.81 (Noncompliance With Treatment), V61.1 (Partner Relational Problem) (Physical or Sexual Abuse of Adult), V61.20 (Parent-Child Relational Problem), V61.21 (Sexual or Physical Abuse or Neglect of Child), V61.8 (Sibling Relational Problem, V61.9 (Relational Problem Related to a [a mental Disorder or General Medical Condition]), V62.2 (Occupational Problem), V62.3 (Academic Problem), V62.4 (Acculturation Problem), V62.81 (Relational Problem Not Otherwise Specified), V62.82 (Bereavement), V62.89 (Phase of Life Problem) (Religious or Spiritual Problem) (Borderline Intellectual Functioning), V65.2 (Malingering), V71.01 (Adult Antisocial Behavior), V71.02 (Child or Adolescent Antisocial Behavior), V71.09 (No Diagnosis or Condition on Axis I or Axis II). This exception does not extend to children five (5) years of age or younger for diagnostic codes V61.20 (Parent-Child Relational Problem) through V61.21 (Neglect, Physical Abuse or Sexual Abuse of Child) and V62.82 (Bereavement).

Non-Participating Provider

Non-Participating Provider means an *Outpatient Surgical Facility*, *Home Health Provider*, *Hospital, Qualified Practitioner, Qualified Treatment Facility,* or *Skilled Nursing Facility* that does not have a written agreement with *Providence Health Plan* to participate as a health care provider for this *Plan*.

Out of Plan

The level of benefit specified in the Summary of Benefits for covered services provided by a non-participating provider.

Out-Of-Pocket Maximum

Out-of-Pocket Maximum means the calendar-year threshold at which this *Plan* will begin to pay for *Covered Services* at 100%, as follows:

1. Individual *Out-of-Pocket Maximum* means the amount of *Coinsurance* and *Copayment* within a calendar year, as shown in the *Summary of Benefits*, that a *Member* must pay before this *Plan* will provide 100% benefits* for additional *Covered Services* within the calendar year.
2. Family *Out-of-Pocket Maximum* means the combined amount of *Coinsurance* and *Copayment* within a calendar year, as shown in the *Summary of Benefits*, that all *Family Members* must pay before this *Plan* will provide 100% benefits* for additional *Covered Services* within the calendar year. The family *Out-of-Pocket Maximum* will be satisfied if:
    - Three *Family Members* each meet their individual *Out-of-Pocket Maximum*, or
    - Four or more *Family Members* have combined *Coinsurance* or *Copayment* expenses that meet the family *Out-of-Pocket Maximum* amount.

The following *Participant*-paid amounts do NOT accumulate toward the *Out-of-Pocket Maximum*:

1. *Services* not covered by this *Plan*;
2. *Services* in excess of any maximum benefit limit;
3. Fees in excess of the *Usual, Customary and Reasonable (UCR)* charges;
4. *Copayments* or *Coinsurance* for a *Covered Service* if indicated on the *Summary of Benefits* as not applicable* to the *Out-of-Pocket Maximum;*
5. *Copayments* or *Coinsurance* for prescription drugs;
6. Any penalties a *Participant* must pay for failure to obtain the required *Prior Authorization* for specified *Services*;
7. *Copayments* or *Coinsurance* for infertility *Covered Service,*
8. *Copayments* or *Coinsurance for alternative care services, and*
9. *Copayments* or *Coinsurance for hearing exams or hearing aids.*.

* *Covered Services* that are indicated in the *Summary of Benefits* as not applicable to the *Out-of-Pocket Maximum* are NOT eligible for 100% benefits. The *Copayment* or *Coinsurance* for those *Services* that is shown in the *Summary of Benefits* remains in effect throughout the calendar year.

Outpatient Surgical Facility

Outpatient Surgical Facility means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does NOT provide *Services* or accommodations for patients to stay overnight.

Participant

Participant means a *PEBB Member* or an *Eligible Family Dependent* who is properly enrolled in this *Plan*, and entitled to *Services* under this *Plan*.

Participating Provider

Participating Provider means an *Outpatient Surgical Facility, Home Health Provider, Hospital, Qualified Practitioner, Qualified Treatment Facility* or *Skilled Nursing Facility* that has a written agreement with *Providence Health Plan* to participate as a health care provider for this *Plan*. For Native American *Participants, Covered Services* obtained through the Indian Health Services are considered to be *Covered Services* obtained from a *Participating Provider*.

PEBB

PEBB means the Oregon Public Employees' Benefit Board, the sponsor of this *Plan*.

PEBB Member

PEBB Member means an Oregon public employee or former employee who is eligible for enrollment in this *Plan* in accordance with the provisions specified in the PEBB Eligibility Handbook and the Oregon Administrative Rules, Chapter 101.

Plan

Plan means the group health plan sponsored by *PEBB*, as summarized in this *Member Handbook*.

Plan Year

Plan Year means the 12-month period ending on December 31st.

Portability Plan

Portability Plan means an individual plan of continuation coverage, as specified in the Oregon Insurance Code, which is available to Oregon residents who lose coverage under a group *Health Benefit Plan***.**

Prior Authorization

Prior Authorization or *Prior Authorized* means a request to *Providence Health Plan* by *You* or by a *Qualified Practitioner* regarding a proposed *Service,* for which prior approval is granted by *PHP*. *Prior Authorization* review will determine if the proposed *Service* is eligible as a *Covered Service* or if an individual is a *participant* at the time of the proposed *Service*. *Prior Authorization* is subject to the terms and provisions of this *Member Handbook*. *Services* that require *Prior Authorization* are shown in the "How to Use *Your Plan*" section of this *Member Handbook*. *Prior Authorization* is not a guarantee of benefit payment (e.g., if the *participant's* coverage terminates before the *Prior Authorized* procedure is performed).

Providence Choice Network

Providence Choice Network means the network of *Participating Providers* in Clackamas, Multnomah, Washington and Yamhill counties that *Participants* may access for *Covered Services* under this *Plan*.

Providence Health Plan (PHP)

Providence Health Plan or *PHP* means the nonprofit corporation authorized as a health care service contractor in the states of Oregon that serves as the claims administrator with respect to this *Plan*.

Qualified Practitioner

Qualified Practitioner means a physician, women's health care provider, nurse practitioner, nurse practitioner midwife, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides *Covered Services* within the scope of that license.

Qualified Treatment Facility

Qualified Treatment Facility means a facility, institution or clinic duly licensed by the appropriate governmental agency, which is primarily established and operating within the lawful scope of its license.

Reconstructive Surgery

Reconstructive Surgery means surgery that restores features damaged as a result of injury or illness or to correct a congenital deformity or anomaly that results in a functional impairment.

Service

Service mean a health care related procedure, surgery, consultation, advice, diagnosis, referrals, treatment, supply, medication, prescription drug, device or technology that is provided to a *Participant* by a *Qualified Practitioner*.

Service Area

Service Area means the four Oregon counties of Clackamas, Multnomah, Washington and Yamhill within which *Providence Choice Network* providers are available to deliver *Covered Services* under this *Plan*.

Skilled Nursing Facility

Skilled Nursing Facility means a convalescent or chronic disease facility which is accredited by the Joint Commission on Accreditation of Hospitals or certified as a "*Skilled Nursing Facility*" by the Secretary of Health and Human Services pursuant to Title XVIII of the Social Security Act as amended.

Summary of Benefits

Summary of Benefits means the provisions specified in section 2 of this *Member Handbook*.

Urgent/Immediate Care

Urgent/Immediate Care means *Services* that are provided for unforeseen, non-life threatening, minor illnesses and injuries which require immediate attention such as ear, nose and throat infections and minor sprains and lacerations.

Usual, Customary and Reasonable (UCR)

When a *Service* is provided by a *Participating Provider*, *UCR* means the fees that *Providence Health Plan* has negotiated with *Participating Providers* for that *Service*. *UCR* charges will never be less than our negotiated fees.

When a *Service* is provided by a *Non-Participating Provider*, *UCR* charges will based on the lesser of:

1. The fee a professional provider usually charges for a given *Service*;
2. A fee which falls within the range of usual charges for a given *Service* billed by most professional providers in the same locality who have similar training and experience;
3. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
4. The fee determined by comparing charges for similar *Services* to a national database adjusted to the geographical area where the *Service* was performed.

UCR charges do not include sales taxes, handling fees and similar surcharges and such taxes, fees and surcharges are not covered expenses.

Women's Health Care Provider

A *Women's Health Care Provider* means an obstetrician or gynecologist, or physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health or certified nurse midwife, practicing within the applicable lawful scope of practice.

You and Your

You and *Your* means a *PEBB Member* or other *Participant*.